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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigations #86564 and #85212.	F 000		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: The facility reported a census of 36 residents with 6 in the sample. Based on observation, interview, and record review the facility failed to review and revise care plans for 5 of 6 residents regarding falls, nail care, and pressure ulcers. (#1, #2, #3, #4, #6) Findings included:	F 280		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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- Review of the resident #2 ' s significant change MDS (Minimum Data Set) dated 2/9/15 revealed a BIMS (Brief Interview for Mental Status) score of 0, indicating severe cognitive impairment. The resident required extensive assistance of 2 or more staff for bed mobility, transfers, and toileting. The resident had frequent bowel and bladder incontinence and had a toileting program. The resident did not experience falls after admission.

Review of the Fall CAA (Care Area Assessment) dated 2/17/15 revealed the resident had short and long term memory loss with confusion. The resident fell on 12/20/14 when staff assisted him/her from the chair. The resident depended on staff for his/her ADL (activities of daily living) care. The resident had been recently hospitalized pneumonia and his/her physical functioning had declined since his/her return. Thee resident needed assistance with transfers and ambulation, cues and reminders, and needed more help at meal times.

Review of a quarterly MDS dated 5/15/15 revealed the resident had a short and long-term memory problem and severely impaired cognitive skills for daily decision making. The resident required extensive assistance of 2 or more staff for bed mobility, transfers, walking in the room and corridor, toileting, and personal hygiene. The resident had one minor injury fall and one fall without injury.

Review of the resident ' s care plan, last reviewed by staff on 5/13/15, revealed interventions directed staff to:
*2/10/14: walk with the resident if he/she had

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anxiety and wanted to walk, monitor the resident ' s whereabouts at all times, respond to safety alarms immediately, keep the resident ' s call light in reach, and toilet the resident every 2 hours during the day, before and after meals, and 3-4 times at night.
*2/14/14: be aware the resident refused to call for assistance with transfers and ambulation, keep areas free of clutter, and complete a fall assessment every 3 months.
*12/20/14: revealed the resident fell and to assess for dizziness or blood loss with cares and assist with 1 staff for ambulation, sitting, or lying down PRN (as needed).
*2/18/15: provide assistance of 2 staff with transfers and at times use the stand-up lift (mechanical lifting/transfer device), keep furniture in the same place in his/her room, escort the resident to meals and other activities, and leave the resident in a safe position and return at a later time if the resident became upset with transfers.
*3/26/15: use a bed alarm to alert staff if the resident got out of bed unassisted.
*4/26/15: the resident fell. The care plan did not alert staff to the resident ' s injury that occurred with the fall or the care of the injury. Staff failed to updated the care plan with an interventions to prevent further falls until 4/29/15.
*4/29/15: monitor and redirect the resident if he/she left the locked unit living room area without staff.
*4/30/15: use a chair alarm for the resident.
*5/8/15: the resident fell and staff were to check the resident hourly and re-orient the resident to his/her environment.

Review of a fall investigation dated 4/26/15 at 5:35 PM revealed staff found the resident on the floor at the north end of the hall after a fall when

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he/she attempted to get up without assistance. Administrative nurse J reviewed the incident on 5/1/15 and recommended the resident be supervised at all times when not in the locked unit living/dining room area, except when in bed. Staff placed a chair alarm on the resident ' s wheelchair. The investigation also revealed the resident sustained injuries to his/her upper lip and left palm that required stitches. The investigation did not include causal factors for the fall.

Observation on 6/17/15 at 11:53 AM revealed the resident sat in a chair in the living room area with his/her feet raised. The resident wore a gait belt and house slippers. He/she did not have any viable bruises. The resident had a 1/2 tennis ball sized lump to his/her left forehead. The resident had his/her eyes closed and snored. He/she had a personal pressure alarm in place.

Interview with direct care staff G on 6/18/15 at 11:34 AM revealed if he/she had a question about a resident ' s care, he/she looked in the chart, or on his/her pocket sheet, which had care plan information on it. Staff G reported every time something changed, the nurses passed it on. Staff G reported he/she used the care plan sometimes.

Interview with administrative nursing staff J on 7/14/15 at 2:12 PM revealed the MDS Coordinator updated the care plans routinely and spent time each day updating changes that needed to be made. Staff J reported the care plans were used to provide information to staff about the care each resident needed to receive from staff including assistance with their ADLs (activities of daily living).

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Review of the facility policy for Care Plan Completion and updating, last revised 12/2011, revealed the charge nurses were responsible for updating care plans within the electronic medical record for changes in the residents' condition including but not limited to: infections with antibiotic therapy, wound treatments, pressure reduction interventions, fall interventions, medication changes and adjustments, hospice care, changes in the resident's condition, comfort care, nutritional/diet changes, feeding assistance, any other situation that changed the care being provided to the resident at that time.

The facility failed to review and revise the resident ' s care plan with new interventions to prevent further falls.

- Review of resident #6's physician order summary dated 5/12/15 revealed the resident had a diagnosis of diabetes mellitus (when the body cannot use glucose and not enough insulin is made or the body cannot respond to the insulin).

Review of the annual MDS (minimum data set) dated 8/8/14 revealed the resident had short and long-term memory problems and severely impaired cognitive skills for daily decision making. The resident had total dependence on two or more staff for personal hygiene.

Review of the Cognitive Loss/Dementia CAA (care area assessment) dated 8/8/14 revealed the resident had a diagnosis of senile dementia and had short and long-term memory loss with confusion. The resident was alert and able to make some of his/her basic needs known such as thirst and hunger. The resident depended on staff for his/her ADL cares.

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Review of the quarterly MDS dated 5/7/15 revealed no change from the previous assessment.

Review of the resident's care plan dated 2/5/15 revealed the resident was diabetic and required assistance of one staff for personal hygiene. It did not address diabetic fingernail care.

Observation on 6/17/15 at 3:30 PM revealed the resident's fingernails were clean, free of debris, and trimmed.

Interview with direct care staff G on 6/18/15 at 11:34 AM revealed activity staff completed the resident ' s nail care by painting and trimming them. Staff G reported if he/she had a question about the resident's care, he/she looked in the chart, or on his/her pocket sheet, which had care plan information on it. Staff G reported he/she used the care plan sometimes.

Interview with licensed nurse I on 6/18/15 at 1:54 PM revealed the resident was diabetic; the nurses completed his/her nail care weekly.

Interview with administrative nursing staff J on 7/14/15 at 2:12 PM revealed the MDS Coordinator updated the care plans routinely and spent time each day updating changes that needed to be made. Staff J reported the care plans were used to provide information to staff about the care each resident needed to receive from staff including assistance with their ADLs (activities of daily living).

Review of the facility policy for Care Plan Completion and updating, last revised 12/2011,

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revealed the charge nurses were responsible for updating care plans within the electronic medical record for changes in the residents' condition including but not limited to: infections with antibiotic therapy, wound treatments, pressure reduction interventions, fall interventions, medication changes and adjustments, hospice care, changes in the resident's condition, comfort care, nutritional/diet changes, feeding assistance, any other situation that changed the care being provided to the resident at that time.

The facility failed to update the resident ' s care plan to include diabetic nail care.

- Review of resident #3 ' s admission MDS (Minimum Data Set 3.0, a required assessment) dated 1/8/15 revealed BIMS (Brief Interview for Mental Status) of 7, indicating severe cognitive impairment. The resident required extensive assistance of two or more staff for bed mobility, transfers, toileting, and personal hygiene. The resident was frequently incontinent of bladder and on a toileting program. The resident had a fall in the 2-6 months prior to admission with a fracture related to a fall during that time. The resident had one minor injury fall since admission.

Review of the Fall CAA (Care Area Assessment) dated 1/9/15 revealed the resident had diagnoses of: status post ORIF (open reduction and internal fixation- a surgical procedure to repair a hip fracture)of the right hip, CVA, depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), atrial fibrillation, osteoarthritis, hypertension, and dementia (progressive mental disorder characterized by failing memory, confusion). The resident was alert and oriented to

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self and family. The resident was dependent on staff for his/her ADL (activities of daily living) cares, with cues and reminders. The resident used a stand up lift (mechanical lifting/transferring device) with 2 staff due to weakness and pain in both lower extremities. The resident could use his/her call light for assistance and to make his/her want/needs known. The resident did not generally attempt to get up from bed or the chair without assistance. When asked if he/she could stand up and walk without assistance he/she replied no.

Review of the ADL CAA dated 1/9/15 revealed the resident could alert staff of the need to use the toilet, usually had urinary incontinence, dribbled urine as soon as staff removed his/her brief, and then finished in the toilet.

Review of a quarterly MDS assessment dated 4/10/15 revealed a BIMS score of 3, indicating severe cognitive impairment. The resident required extensive assistance of two or more staff for bed mobility, transfers, toileting, and personal hygiene and was occasionally incontinent of bladder. The resident fell in the 2-6 months prior to admission with a hip fracture and did not fall since the previous assessment.

Review of the care plan last reviewed revealed the following interventions with implementation dated:
12/29/14:
· Offer and assist the resident to toilet every 2 hours and as needed,
· Encourage resident to get out of bed daily as tolerated.
1/12/15:
· Ensure Call light in reach. Remind what it is

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and what it was for,
· Offer to toilet the resident as he/she had occasional bowel and/or bladder incontinence. Check every 2 hours and PRN.
· Transfer with a stand up lift with 2 staff.
· Provide assistance of one staff f for bed mobility.
1/13/15:
· Provide assistance of one or two staff for transfers and ambulation.
· Complete fall risk assessment every 3 months.
· Remind the resident to wait for assistance from staff.
· Consult physical therapy to help improve mobility
· Use bed alarm and ensure it worked properly, Place the bed against the wall to define parameters
1/23/15:
· Use a fall mat on the floor next to the bed when the resident lay in bed.

Review of a fall investigation dated 1/3/15 revealed staff found the resident lying on the floor on his/her right side beside his/her bed facing the window after he/she called for help from nursing staff. The resident had a bed with bolstered (raised) sides and the call light was in reach. The resident stated he/she attempted to get up and go to the bathroom. The resident did not have a history of getting up without assistance. Administrative nursing staff J reviewed the incident on 1/21/15 (2 ½ weeks after the fall) and made recommendations to use a bed alarm on the bed, a fall mat on the floor beside the bed, and use the established toileting plan for the resident. Staff failed to update the resident ' s care plan with these planned interventions until

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1/13/15 and 1/23/15.

Observation at 12:36 PM direct care staff L and licensed nursing staff C transferred the resident onto the toilet using a sit-to-stand lift. The resident requested to sit a while and Staff L gave the resident his/her call light, closed the door and left down the hall.

Interview with direct care staff G on 6/18/15 at 11:34 AM revealed if he/she had a question about the resident's care, he/she looked in the chart, or on his/her pocket sheet, which had care plan information on it. Staff G reported he/she used the care plan sometimes.

Interview with direct care staff B on 6/18/15 at 11:14 AM revealed if he/she had a question about the resident ' s cares, he/she looked in the chart for information, his/her pocket sheet that had information on it about each of the resident ' s needs, or in the care plan books at the desk. Staff B reported the care plan included all the resident ' s cares, what staff needed to be doing for them, and were very individualized.

Interview with administrative nursing staff J on 7/14/15 at 2:12 PM revealed the MDS Coordinator updated the care plans routinely and spent time each day updating changes that needed to be made. Staff J reported the care plans were used to provide information to staff about the care each resident needed to receive from staff including assistance with their ADLs (activities of daily living).

Review of the facility policy for Care Plan Completion and updating, last revised 12/2011, revealed the charge nurses were responsible for

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updating care plans within the electronic medical record for changes in the residents' condition including but not limited to: infections with antibiotic therapy, wound treatments, pressure reduction interventions, fall interventions, medication changes and adjustments, hospice care, changes in the resident's condition, comfort care, nutritional/diet changes, feeding assistance, any other situation that changed the care being provided to the resident at that time.

The facility failed to update resident #3 ' s care plan with new interventions in a timely manner after he/she fell out of bed.

- Review of resident #4's quarterly MDS dated 2/5/15 revealed a BIMS score of 9, indicating moderate cognitive impairment. Per the MDS resident #4 required total assistance of 2 or more staff for bed mobility, transfers, and toileting. Resident #4 required supervision and set-up for eating. Resident #4 had an indwelling urinary catheter (tube inserted into the bladder to drain urine into a collection bag) and always had bowel incontinence. Staff provided the resident a therapeutic diet and resident #4 had not experienced any weight loss. Staff determined resident #4 had a risk of developing a pressure ulcer and had an unhealed stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon or muscle, slough or eschar (dead tissue) may be present, often includes undermining and tunneling) that measured 2.9 cm (centimeters) x 3.0 cm x 0.5 cm deep. The pressure ulcer had eschar present. The staff implemented the following interventions: a pressure reducing device for the chair and bed, a turning/repositioning program, nutritional/hydration interventions, pressure ulcer

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care, and the application of non-surgical dressings. There were no pressure ulcers present in the previous assessment.

Review of an annual MDS dated 5/4/15 revealed resident #4 had a BIMS score of 11, indicating moderate cognitive impairment. The resident required extensive assistance of 2 or more staff for bed mobility. He/she required total assistance of 2 or more staff for transfers and toileting. The resident had an indwelling catheter and always had bowel incontinence. Staff determined the resident had a risk for the development of pressure ulcers, but did not have any unhealed pressure ulcers at the time of assessment. The resident did have an open lesion other than an ulcer, rash or cut and used a pressure reducing device for the chair and bed, a turning/repositioning program, and nutritional/hydration interventions.

Review of the Pressure Ulcer CAA (Care Area Assessment) dated 5/7/15 revealed resident #4 did not have any pressure ulcers at the time. The assessment revealed resident #4 had a recent flap repair to a wound on his/her buttocks, which had resolved without complications. The assessment also revealed resident #4 depended on staff for ADL (activities of daily living) cares, transferred via lift sling, and depended on staff for repositioning in the bed and chair. Resident #4 had a Roho cushion (a wheelchair cushion) in his/her chair and low air loss mattress on his/her bed. The resident had a Foley catheter (brand of indwelling urinary catheter), had bowel incontinence, and wore adult protective incontinent products.

Review of the Nutritional Status CAA dated 5/7/15

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revealed resident #4 received a NCS (no concentrated sweets) diet with a protein supplement TID (three times a day). Resident #4 preferred Special K (brand of supplement) and watched his/her weight limiting and often refusing desserts and breads. The resident asked for small portions and ate 50-100% of his/her meals. Resident #4 could make his/her own menu choices and feed him/herself after set-up from staff. He/she needed to have meals and drinks placed where he/she could easily reach items as he/she had a limited reach. The resident had a plate guard on his/her plate at meal times. He/she also preferred to sleep in the mornings and usually did not eat breakfast.

Review of the ADL CAA dated 5/7/15 revealed resident #4 had a diagnosis of MS (multiple sclerosis), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and dementia (progressive mental disorder characterized by failing memory, confusion). The resident was hospitalized in 2/2015 for flap repair to his/her buttocks wound that resolved well. The resident had a sitting limit of 90 minutes at a time TID and needed reminders of this limit due to the resident wanted to sit up longer. Resident #4 complied with the sitting limit after explanation provided. The resident depended on staff for ADL care, transferred via lift sling, needed staff to reposition him/her, made his/her needs known, and fed him/her after set-up assist.

Review of resident #4 ' s care plan, last reviewed by staff on 5/6/15, revealed the resident totally depended on staff for ADLs. The following interventions were dated 10/30/12:
*Assist the resident to remember things, as

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he/she had poor memory
*Be aware the resident had total bowel incontinence and an indwelling urinary catheter
*Keep the resident clean and dry by checking and changing him/her every 2 hours
*Provide assistance of 2 or more staff for bed mobility
*Pressure reducing cushion on the wheelchair
*Bed buddy system to assist with repositioning
*Bolstered sides on the bed
*Use a low air loss, alternating pressure mattress on his/her bed at all times
*Be sure the mattress functioned correctly each time in the resident ' s room and before putting to bed
*Reposition the resident every 2 hours and as needed when in bed
*When not in bed, please reposition the resident at least every 20 minutes
*Use a Hoyer lift (full mechanical lift) for transfers
*Perform weekly skin assessments
*Provide set-up assistance at mealtime
*Educate the resident on the importance of protein as he/she tended to cut back on meats to decrease calorie consumption since he/she wanted to lose weight
*Weigh the resident weekly
*Dietician assessment every 3 months
*Administer vitamin supplements daily as ordered
*Monitor food intake at meals and snacks
*Assist the resident with a supplement each day and encourage him/her to drink it
*Encourage the resident to eat at least 75% of the meal, if not offer a substitute
*Use heel protectors on the resident ' s feet so the heels did not get skin breakdown
*Use proper positioning, transferring, and turning techniques to minimize skin injury due to friction/shear forces

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*Use pillows when in bed to ensure bony prominences were not touching each other
Staff revised the care plan on:
*2/11/13- staff were to remind resident #4 of the importance of eating as he/she got so focused on weight loss that he/she forgot he/she needed nutrition and calories for wound healing and use pillows to assist with positioning and off-loading the weight on his/her legs, ankles, and feet.
*6/19/13- staff were to reposition the resident every 90 minutes and ensure the resident received increased protein with his/her meals for proper skin/wound prevention.
*2/4/14- resident #4 requested small portions and if he/she was still hungry, he/she asked for more.
*2/7/14- staff used a halo bed system to assist with turning and repositioning.
*8/5/14-the staff were to use a non-slip cover on the resident's Roho cushion at all times.
*12/17/14- ensure the resident used a plate guard so the food did not fall off his/her plate
*2/12/15- provide a Special K drink with each meal.
*3/24/15- the resident had a flap repair (surgical wound repair) to the wound on his/her buttocks, the resident was to be up for meals only, staff were to assist the resident up for meals and then to lay back down, and administer Multivitamin and Zinc to promote wound healing.
*3/26/15- staff were to get the resident up for meals for 30 minutes and increase the time by 15 minutes per day until he/she was up for 90 minutes at a time and monitor flap site daily until resolved.
The care plan contained many inconsistencies regarding how often staff needed to reposition the resident. Staff failed to revise the care plan as the resident ' s repositioning requirements changed.

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Review of the resident's progress notes revealed: *3/26/15-Staff received an order regarding the resident's sitting restrictions for the resident to sit 2-3 times per day for 30 minutes at a time. Increase the resident ' s sitting time by 15 minutes daily until reaching 90 minutes at a time and sit only on a Roho cushion so it was well padded.

Interview with direct care staff G on 6/18/15 at 11:34 AM revealed if he/she had a question about the resident's care, he/she looked in the chart, or on his/her pocket sheet, which had care plan information on it. Staff G reported he/she used the care plan sometimes.

Interview with direct care staff B on 6/18/15 at 11:14 AM revealed if he/she had a question about the resident ' s cares, he/she looked in the chart for information, his/her pocket sheet that had information on it about each of the resident ' s needs, or in the care plan books at the desk. Staff B reported the care plan included all the resident ' s cares, what staff needed to be doing for them, and were very individualized.

Interview with administrative nursing staff J on 7/14/15 at 2:12 PM revealed the MDS Coordinator updated the care plans routinely and spent time each day updating changes that needed to be made. Staff J reported the care plans were used to provide information to staff about the care each resident needed to receive from staff including assistance with their ADLs (activities of daily living). Staff J could not explain why there were so many different guidelines in the resident ' s care plan for repositioning.

Review of the facility policy for Care Plan

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Completion and updating, last revised 12/2011, revealed the charge nurses were responsible for updating care plans within the electronic medical record for changes in the residents' condition including but not limited to: infections with antibiotic therapy, wound treatments, pressure reduction interventions, fall interventions, medication changes and adjustments, hospice care, changes in the resident's condition, comfort care, nutritional/diet changes, feeding assistance, any other situation that changed the care being provided to the resident at that time.

The facility failed to revise resident #4 ' s care plan interventions related to how often staff were to reposition him/her.

- Review of resident #1 ' s annual MDS (Minimum Data Set) assessment dated 10/6/14 revealed a BIMS (Brief Interview for Mental Status) score of 11, indicating moderate cognitive impairment. The resident required limited assistance of 1 staff for transfers and toileting. He/she was independent with walking in the room and corridor, and locomotion on the unit. The resident had frequent urinary incontinence and occasional bowel incontinence and currently participated in a toileting program. The resident had one non-injury fall since the previous quarterly assessment.

Review of the Fall CAA (Care Area Assessment) dated 10/13/14 revealed resident #1 had a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion) and bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods). Resident #1 fell on 10/5/14 when he/she tried to get comfortable in

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the recliner and slid to the floor. Resident #1 ambulated by him/herself without supervision within the unit and with supervision outside the unit. He/she had a slightly shuffled gait and could fully bear weight. The resident was oriented to his/her surroundings and aware of important areas within the unit. He/she needed cues and reminders as well as limited assistance with ADL (activities of daily living) cares. As his/her dementia progressed, his/her physical functioning continued to decline.

Review of the ADL CAA dated 10/13/14 revealed resident #1 had frequent bowel and bladder incontinence. Resident #1 knew where the bathrooms were located, but staff needed to remind him/her to use the bathroom and provide the resident with incontinent hygiene as needed. The resident wore adult incontinence products and if he/she took it off, he/she did not always put a clean one on.

Review of a 4/3/15 quarterly MDS assessment revealed a BIMS score of 3, indicating severe cognitive impairment. Resident #1 required limited assistance of 1 staff for bed mobility, transfers, walking in the room and corridor, locomotion on the unit, and he/she required extensive assistance with toileting and personal grooming. The resident had one non-injury fall and one minor injury fall since the previous assessment.

Review of resident #1's care plan, initiated 10/12/12, revealed the resident had a history of falls. Interventions directed staff to:
*Monitor for orthostatic hypotension (a form of low blood pressure that occurred from standing up from sitting or lying down)

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*Take the resident's blood pressure prior to administering blood pressure medications daily.
*Provide the resident a night light in his/her room
*Sit with the resident and help him/her get back to sleep when he/she woke up unexpectedly
*Keep the call light within reach
*Provide activities throughout the day
*After each un-witnessed fall, complete neurological checks as per facility policy
*Report all falls with injury to the physician immediately
*Encourage the resident to wear shoes for ambulation
*Monitor and decrease the resident ' s psychotropic medications per facility policy
*Remove obstacles from the resident's path
*Complete a fall risk assessment every 3 months. If the fall risk increased, staff were to implement new interventions to prevent falls.
Staff revised the care plan on:
*10/6/14 -assist the resident to an upright position in his/her recliner in the event he/she began to slide down.
*11/20/14- the resident experienced a fall, staff were to assist resident #1 with ambulation to and from meals.
*12/4/14- the staff found the resident on the floor in another resident's room. Staff were to re-direct the resident out of other resident's rooms and provide appropriate supervision.
*1/16/15- the resident fell, no new interventions were added.
*3/14/15- the resident fell while ambulating to his/her room with assistance. Staff were to ambulate with the resident with a gait belt when the resident felt dizzy.
*4/3/15- the resident fell. Staff were to use 2 staff to assist the resident if he/she had weakness or dizziness.

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*4/23/15- the resident fell on 4/20/15. Staff used a bed alarm to alert staff when the resident tried to get up.
*4/29/15- resident #1 fell on 4/28/15. Staff used a chair alarm when the resident sat in the chair.
* 5/8/15- staff were to ensure:
1. Resident #1's bed alarm and chair alarm worked at all times.
2. A clear visual path from the dining room to the resident's recliner.
3. Use of a chair alarm in the recliner and dining chair.
4. Use of a halo bed buddy system for positioning in bed.
5. The resident had continuous oxygen via nasal cannula to maintain oxygen saturations above 90%.
6. To provide assistance to the resident with a gait belt for ambulation.
7. To toilet the resident every 1.5-2 hours.
8. To provide activities for the resident when he/she got up at night.
The resident's care plan did not address the injury to the resident's ear or the care/monitoring it required after a fall on 4/28/15.

Review of a Fall Investigation dated 1/16/15 at 1:10 AM revealed staff found resident #1 after he/she fell in his/her room while attempting to get out of bed unassisted. The Fall Investigation revealed administrative nurse J reviewed the investigation on 2/9/15 (3 ½ weeks later) and he/she recommended a bed alarm to the resident ' s bed, continue other fall precautions, and consistent reminders to ring and wait for assistance. Staff failed to add an intervention to the resident ' s care plan to prevent further falls.

Review of a Fall Investigation dated 1/16/15 at

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9:30 PM (a second fall on that day) revealed staff found resident #1 on the floor in the hallway by the fire doors. The Fall Investigation revealed administrative nurse J reviewed the investigation on 2/9/15 (3 ½ weeks later) with a recommendation to routinely check on the resident when he/she was in his/her room to prevent falls. Staff failed to add the intervention to the care plan.

Review of a Fall Investigation dated 3/14/15 at 9:00 PM revealed staff lowered resident #1 to the floor during ambulation because the resident felt weak and dizzy. Staff determined the cause of the fall was due to his/her cancer treatments and weekly chemotherapy. The Fall Investigation revealed administrative nurse J reviewed the investigation on 4/30/15 (about a month and ½ later) and made recommendations to ambulate with the resident using 2 staff if the resident felt weak or dizzy or put the resident in the wheelchair if he/she appeared too weak to ambulate distances. Staff failed to update the care plan with the recommendation to include the entire recommendation.

Review of a Fall Investigation dated 4/20/15 at 6:00 AM revealed staff found resident #1 on the floor by his/her bed on his/her buttocks. Per the investigation the resident stated he/she was trying to get up, but the investigation did not indicate why the resident tried to get up. The Fall Investigation revealed administrative nurse J reviewed the investigation on 5/1/15 (11 days later) and recommended the bed in low position and bed alarm in place at all times when the resident rested in bed. Staff failed to include an intervention related to the position of the bed when the resident lay in bed.

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Review of a Fall Investigation dated 4/28/15 at 3:30 PM revealed staff found resident #1 on the floor in another resident's bathroom with a laceration and minor bleeding to his/her left ear. Per the investigation the resident had bowel and bladder incontinence at the time of the fall. The resident reported he/she fell and hit his/her ear on the toilet. Staff sent the resident to the ER (emergency room) for sutures and examination.

Review of a progress note dated 4/28/15 at 4:48 PM revealed staff found resident #1 in another resident ' s room. Per the note the resident had an incontinent bowel and bladder episode and had fallen. The note revealed the resident stated he/she had hit his/her left ear on the toilet. Staff indicated in the note that resident #1 had bleeding and a laceration to the top part of his/her ear, staff cleaned the resident up, and sent the resident to the ER (emergency room).

Review of the ER report dated 4/28/15 revealed the resident presented with a laceration to his/her left ear. Per the resident the resident could not tell staff how it happened. The report indicated the resident had a 4.5 cm (centimeter) laceration to the left ear that involved underlying cartilage. The physician noted he/she sutured approximately a 7 cm total area.

Review of a progress note dated 4/28/15 at 8:10 PM revealed the resident returned from the ER with orders for Keflex (an antibiotic) 500 mg (milligrams) by mouth BID (twice a day) for 10 days and Bacitracin ointment (used to prevent minor skin infections) to sutures BID for 7 days. Resident #1 was scheduled for suture removal at the clinic on 5/4/15.

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Observation on 4/30/15 at 4:44 PM revealed resident #1 lay in a recliner in the dining room with the foot rest partially up. The resident had tennis shoes on and his/her eyes were closed. The resident's left ear had a laceration across the ear.

Interview with direct care staff G on 6/18/15 at 11:34 AM revealed if he/she had a question about the resident's care, he/she looked in the chart, or on his/her pocket sheet, which had care plan information on it. Staff G reported he/she used the care plan sometimes.

Interview with direct care staff B on 6/18/15 at 11:14 AM revealed if he/she had a question about the resident ' s cares, he/she looked in the chart for information, his/her pocket sheet that had information on it about each of the resident ' s needs, or in the care plan books at the desk. Staff B reported the care plan included all the resident ' s cares, what staff needed to be doing for them, and were very individualized.

Interview with administrative nursing staff J on 7/14/15 at 2:12 PM revealed the MDS Coordinator updated the care plans routinely and spent time each day updating changes that needed to be made. Staff J reported the care plans were used to provide information to staff about the care each resident needed to receive from staff including assistance with their ADLs (activities of daily living).

Review of the facility policy for Care Plan Completion and updating, last revised 12/2011, revealed the charge nurses were responsible for updating care plans within the electronic medical

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F 280	Continued From page 23 record for changes in the residents' condition including but not limited to: infections with antibiotic therapy, wound treatments, pressure reduction interventions, fall interventions, medication changes and adjustments, hospice care, changes in the resident's condition, comfort care, nutritional/diet changes, feeding assistance, any other situation that changed the care being provided to the resident at that time. The facility failed to update resident #1 ' s care plan with planned interventions after several falls, including the care and monitoring the resident ' s injured ear required after a fall on 4/28/15.	F 280		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: The facility reported a census of 36 with 6 residents in the sample. Based on observation, interview, and record review the facility failed to provide fingernail care for 1 of 3 residents reviewed to maintain personal hygiene and grooming. (#2) Findings included: - Review of resident #2 ' s significant change MDS (Minimum Data Set) dated 2/9/15 revealed a BIMS (Brief Interview for Mental Status) score	F 312		

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of 0, indicating severe cognitive impairment. Resident #2 required total assistance of 2 or more staff for personal hygiene.

The ADL (activities of daily living) CAA (Care Area Assessment) did not trigger for further assessment.

Review of the Fall CAA dated 2/17/15 revealed resident #2 had short and long term memory loss with confusion. The resident depended on staff for his/her ADL cares. He/she had been recently hospitalized with pneumonia and his/her physical functioning had declined since his/her return.

Review of a quarterly MDS dated 5/15/15 revealed the resident had a short and long-term memory problem and severely impaired cognitive skills for daily decision making. The resident did not exhibit behaviors. The resident required extensive assistance of 2 or more staff for personal hygiene.

Review of resident #2's care plan dated 5/13/15 revealed there were no interventions on the care plan related to fingernail care for the resident.

Review of the resident's medical record revealed no documentation of nail care.

Observation on 6/17/15 at 11:55 AM revealed resident #2 did not have fingers on his/her right hand. The resident ' s left hand had longer fingernails that were brown around the edges.

Observation on 6/17/15 at 3:32 PM revealed the resident's fingernails remained the same.

Interview with direct care staff G on 6/18/15 at

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F 312	Continued From page 25 11:35 AM revealed the Activities staff did nail care and fingernail trimming for resident #2. Interview with direct care staff H on 6/18/15 at 2:26 PM revealed the CNAs (Certified Nursing Assistant) provided nail care during showers because resident #2 was relaxed at that time. Interview with licensed nursing staff I on 6/18/15 at 1:57 PM revealed resident #2 required quite a bit of assistance. He/she reported staff did resident nail care weekly. He/she reported since resident #2 did not have diabetes the CNAs completed his/her nail care. He/she reported the facility did not have a system for charting nail care. Interview with administrative nursing staff J on 6/18/15 at 11:25 AM revealed he/she could not locate any documentation of fingernail care. Although requested on 6/18/15 at 8 AM, the facility failed to provide a fingernail care policy. The facility failed to provide fingernail care for resident #2 to maintain cleanliness and grooming.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314		

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This REQUIREMENT is not met as evidenced by:
The facility reported a census of 36 residents with 6 residents in the sample. Based on observation, interview, and record review the facility failed to implement planned interventions for repositioning a resident with a history of stage 4 ischial (part of hip bone) pressure wound (full thickness tissue loss with exposed bone, tendon or muscle, often includes undermining and tunneling) that required surgical intervention to heal.

Findings included:

- Review of resident #4's signed physician history and physical dated 2/25/15 revealed the following diagnoses: multiple sclerosis (progressive disease of the nerve fibers of the brain and spinal cord), previous flap closure of coccyx wound, and right ischial (part of the hip bone) wound.

Review of the quarterly MDS dated 2/5/15 revealed a BIMS score of 9, indicating moderate cognitive impairment. Per the MDS resident #4 required total assistance of 2 or more staff for bed mobility, transfers, and toileting. Resident #4 required supervision and set-up for eating. Resident #4 had an indwelling urinary catheter (tube inserted into the bladder to drain urine into a collection bag) and always had bowel incontinence. Staff provided the resident a therapeutic diet and resident #4 had not experienced any weight loss. Staff determined resident #4 had a risk of developing a pressure ulcer and had an unhealed stage 4 pressure ulcer (full thickness tissue loss with exposed bone,

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tendon or muscle, slough or eschar (dead tissue) may be present, often includes undermining and tunneling) that measured 2.9 cm (centimeters) x 3.0 cm x 0.5 cm deep. The pressure ulcer had eschar present. The staff implemented the following interventions: a pressure reducing device for the chair and bed, a turning/repositioning program, nutritional/hydration interventions, pressure ulcer care, and the application of non-surgical dressings. There were no pressure ulcers present in the previous assessment.

Review of an annual MDS dated 5/4/15 revealed resident #4 had a BIMS score of 11, indicating moderate cognitive impairment. The resident required extensive assistance of 2 or more staff for bed mobility. He/she required total assistance of 2 or more staff for transfers and toileting. The resident had an indwelling catheter and always had bowel incontinence. Staff determined the resident had a risk for the development of pressure ulcers, but did not have any unhealed pressure ulcers at the time of assessment. The resident did have an open lesion other than an ulcer, rash or cut and used a pressure reducing device for the chair and bed, a turning/repositioning program, and nutritional/hydration interventions.

Review of the Pressure Ulcer CAA (Care Area Assessment) dated 5/7/15 revealed resident #4 did not have any pressure ulcers at the time. The assessment revealed resident #4 had a recent flap repair to a wound on his/her buttocks, which had resolved without complications. The assessment also revealed resident #4 depended on staff for ADL (activities of daily living) cares, transferred via lift sling, and depended on staff for

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repositioning in the bed and chair. Resident #4 had a Roho cushion (a wheelchair cushion) in his/her chair and low air loss mattress on his/her bed. The resident had a Foley catheter (brand of indwelling urinary catheter), had bowel incontinence, and wore adult protective incontinent products.

Review of the Nutritional Status CAA dated 5/7/15 revealed resident #4 received a NCS (no concentrated sweets) diet with a protein supplement TID (three times a day). Resident #4 preferred Special K (brand of supplement) and watched his/her weight limiting and often refusing desserts and breads. The resident asked for small portions and ate 50-100% of his/her meals. Resident #4 could make his/her own menu choices and feed him/herself after set-up from staff. He/she needed to have meals and drinks placed where he/she could easily reach items as he/she had a limited reach. The resident had a plate guard on his/her plate at meal times. He/she also preferred to sleep in the mornings and usually did not eat breakfast.

Review of the ADL CAA dated 5/7/15 revealed resident #4 had a diagnosis of MS (multiple sclerosis), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and dementia (progressive mental disorder characterized by failing memory, confusion). The resident was hospitalized in 2/2015 for flap repair to his/her buttocks wound that resolved well. The resident had a sitting limit of 90 minutes at a time TID and needed reminders of this limit due to the resident wanted to sit up longer. Resident #4 complied with the sitting limit after explanation provided. The resident depended on staff for ADL

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care, transferred via lift sling, needed staff to reposition him/her, made his/her needs known, and fed him/her after set-up assist.

Review of resident #4 ' s care plan, last reviewed by staff on 5/6/15, revealed the resident totally depended on staff for ADLs. The following interventions were dated 10/30/12:
*Assist the resident to remember things, as he/she had poor memory
*Be aware the resident had total bowel incontinence and an indwelling urinary catheter
*Keep the resident clean and dry by checking and changing him/her every 2 hours
*Provide assistance of 2 or more staff for bed mobility
*Pressure reducing cushion on the wheelchair
*Bed buddy system to assist with repositioning
*Bolstered sides on the bed
*Use a low air loss, alternating pressure mattress on his/her bed at all times
*Be sure the mattress functioned correctly each time in the resident ' s room and before putting to bed
*Reposition the resident every 2 hours and as needed when in bed
*When not in bed, please reposition the resident at least every 20 minutes
*Use a Hoyer lift (full mechanical lift) for transfers
*Perform weekly skin assessments
*Provide set-up assistance at mealtime
*Educate the resident on the importance of protein as he/she tended to cut back on meats to decrease calorie consumption since he/she wanted to lose weight
*Weigh the resident weekly
*Dietician assessment every 3 months
*Administer vitamin supplements daily as ordered
*Monitor food intake at meals and snacks

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*Assist the resident with a supplement each day and encourage him/her to drink it
*Encourage the resident to eat at least 75% of the meal, if not offer a substitute
*Use heel protectors on the resident ' s feet so the heels did not get skin breakdown
*Use proper positioning, transferring, and turning techniques to minimize skin injury due to friction/shear forces
*Use pillows when in bed to ensure bony prominences were not touching each other
Staff revised the care plan on:
*2/11/13- staff were to remind resident #4 of the importance of eating as he/she got so focused on weight loss that he/she forgot he/she needed nutrition and calories for wound healing and use pillows to assist with positioning and off-loading the weight on his/her legs, ankles, and feet.
*6/19/13- staff were to reposition the resident every 90 minutes and ensure the resident received increased protein with his/her meals for proper skin/wound prevention.
*2/4/14- resident #4 requested small portions and if he/she was still hungry, he/she asked for more.
*2/7/14- staff used a halo bed system to assist with turning and repositioning.
*8/5/14-the staff were to use a non-slip cover on the resident's Roho cushion at all times.
*12/17/14- ensure the resident used a plate guard so the food did not fall off his/her plate
*2/12/15- provide a Special K drink with each meal.
*3/24/15- the resident had a flap repair to the wound on his/her buttocks, the resident was to be up for meals only, staff were to assist the resident up for meals and then to lay back down, and administer Multivitamin and Zinc to promote wound healing.
*3/26/15- staff were to get the resident up for

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meals for 30 minutes and increase the time by 15 minutes per day until he/she was up for 90 minutes at a time and monitor flap site daily until resolved.
The care plan contained many inconsistencies regarding how often staff needed to reposition the resident.

Review of Braden Scale for Pressure Ulcer Risk scores dated 11/7/14, 2/6/15, and 5/11/15 revealed a score of 14, indicating moderate risk for pressure ulcers.

Review of the resident's skin condition/wound progression notes revealed the resident had a left lower buttocks wound:
*12/27/14-Staff documented an abrasion to the left gluteal fold that measured 1.4 cm x 1 cm x 0.1 cm with blanchable skin.
*1/1/15-Staff documented the wound continued to heal slowly, but did not document measurements.
*1/7/15-Staff documented the dressing to the wound as dry and intact but did not document measurements.
*1/9/15-Staff documented the left lower buttocks wound as a stage 2 pressure ulcer with blanchable skin and indicated the wound was not present on admission. Staff cleaned the wound with normal saline, safe-gel applied, and packing strip to wound bed, covered with 2 x 2 gauze, and taped in place. Staff documented the wound was healing slowly but did not document measurements.
*1/10/15- Staff documented the stage 2 ulcer to left lower buttocks measured approximately 1.5 cm x 1.3 cm x 0.2 cm.
*1/18/15-Staff documented the area as improving and applied dressing using wet-to-dry technique but did not document measurements.

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*1/26/15-Staff documented the resident ' s stage 2 as blanchable with a faint odor present, and thin, green, scant drainage. Staff described the wound with a pink wound base 25%, white wound base 50%, and black brown base 25%.
*1/28/15-Staff documented the resident ' s wound increased to a stage 3 pressure ulcer (full thickness tissue loss, subcutaneous fat may be visible but bone, tendon or muscle not exposed. Slough may be present but did not obscure the depth of tissue loss). Staff described the wound to have a faint odor, and thin, scant, red-tinged drainage with a white wound base 100%.
*1/3015-Staff documented the stage 2 pressure ulcer measured 2.5 cm x 3 cm x 0.5 cm. with non-blanchable skin, faint odor apparent, thin yellow/tan/red-tinged minimal drainage present. Staff described the wound to have a red wound base 10%, yellow wound base 80%, black/brown wound base 10%, eschar 90%, and slough 10%. Staff changed the dressing and reported the wound had minimal serosanguinous (type of wound drainage) drainage. Saf-gel wet to dry dressing applied per order.
*2/3/15-Staff documented no improvement and reported the wound increased in size with surrounding skin pink, blanchable and hard when palpated but did not document measurements.
*2/8/15-Staff documented the wound dressing changed as ordered using wet-to-moist technique with the packing soaked with Gentamicin solution. Staff documented the area had not been healing well and noted redness to the wound bed as well as sanguineous (type of wound drainage) drainage but did not document measurements.
*2/12/15-Staff documented the wound measured 2.9 cm x 3 cm x 0.9 cm with tunneling starting near the hard area that surrounded the wound.
*2/17/15-Staff documented the wound measured

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2.9 cm x 3 cm x 0.9 cm and had a faint odor present with minimal red-tinged/yellow thin drainage.
*2/21/15-Staff documented resident #4 had surgery scheduled for the following week but did not document measurements of the wound.
*2/23/15-Staff documented no changes to the wound but did not document measurements and noted the resident had surgery scheduled for 2/26/15.
*3/26/15-The resident recently had flap surgery to the open area and returned to the facility on 3/24/15 with the area healed and scattered scabs noted.

Review of the resident's progress notes revealed:
*12/16/14-The resident did not follow his/her diet.
*1/12/15-Staff received orders for Zinc and Multivitamin to promote wound healing.
*1/23/15-Staff faxed the physician reporting the resident had another open area in the same location as the one on his/her left gluteal fold that was being treated with saf-gel and a wet-to-dry dressing. The physician replied in agreement.
*1/29/15-Staff received an order to change the dressing to BID and collect a culture.
*2/2/15-Staff sent a fax to the physician asking for special K protein drink to be given with meals due to condition of the resident's wound. Staff described the wound had brown drainage with a gray wound bed with white and a strong foul odor. Staff called the physician and asked him/her to evaluate the wound.
*2/2/15-The physician noted a decubitus ulcer on the resident ' s left medial buttock and ordered to change the dressing to wet-to-moist and change BID.
*2/3/15-Staff received order for special K protein drink with meals.

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*2/5/15-Staff received new orders for Gentamicin drops to moisten packing strips when packing and change the dressing daily instead of BID.
*2/7/15-A dietary note revealed the resident had experienced a 14.86% weight loss over the past 6 months and weighed 168.4 pounds (lbs.). The resident received a NCS diet with variable intake, generally refused breakfast and some other meals. The resident's weight loss had been beneficial, but further weight loss should be avoided.
*2/9/15-Staff received orders for the resident to be the last resident up and the first resident down, Gentamicin drops to the wound, cover with gauze, and no packing.
*2/18/15-Dietary staff reported the resident had a limited concentrated sweets diet to aid the resident in losing weight, the resident also refused breakfast because he/she wanted to sleep in. The resident received a supplement of choice for added protein. The resident ate 100% of lunch and 25-100% of supper.
*3/26/15-Staff received an order regarding the resident's sitting restrictions for the resident to sit 2-3 times per day for 30 minutes at a time. Increase the resident ' s sitting time by 15 minutes daily until reaching 90 minutes at a time and sit only on a Roho cushion so it was well padded.
*3/31/15-A Dietary note revealed the resident weighed 152 lbs. and received a regular NCS diet. The resident was previously on a protein supplement of choice with meals, but that had not been re-ordered. The resident refused breakfast daily and ate 50-100% of lunch and dinner. He/she received vitamin C and had a wound on his/her buttocks. The dietary staff recommended to reinstate the protein supplement of choice with lunch and dinner to help reduce weight loss and

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aid in wound healing.
*4/27/15-A Dietary revealed the resident requested a snack of special K high protein drink BID. The resident weighed 152.4 lbs.
*4/29/15-Staff received an order for supplement of choice TID with meals.
*5/3/15-Staff revealed the resident was up in the wheelchair for most of late afternoon and evening.
*5/6/15-Staff received an order to change diet to NCS diet as the resident wished to continue to lose weight.
*5/8/15-A Dietary note revealed the resident weighed 153 lbs. He/she received protein supplements TID with meals per resident request. He/she also received vitamin C, calcium carbonate, and zinc.

Review of the 2015 TARs (treatment administration records) revealed:
January-
· Calmoseptine not administered 1 time out of 31 days with no follow-up
· Supplement not administered 12 times out of 31 days with follow-up of that the resident remained in bed at breakfast and declined supplement
· Saf-gel and wet to dry dressing BID not administered 4 times out of 3 days with no follow-up
February-
· Supplement not administered 8 times out of 28 days with follow-up of that the resident remained in bed at breakfast and declined supplement
· Wet to moist dressing to buttock wound BID until healed not administered 3 times out of 4 days with no follow-up
· Wet to moist dressing to buttock wound daily

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not administered 2 times out of 3 days with no follow-up
· Gentamycin (antibiotic) to wound then dry dressing to cover daily for buttock wound not administered 3 times out of 15 days with no follow-up
April 2nd -15th -
· Supplement of choice TID with meals not administered 3 times out of 2 days with follow-up on 4/30 x2 due to refusal.
May-
· Supplement not administered 12 times out of 31 days with follow-up of that the resident remained in bed at breakfast and declined supplement.
June 1st-29th -
· Supplement not administered 12 times out of 31 days with follow-up of that the resident remained in bed at breakfast and declined supplement

Review of a hospital physician progress note dated 3/20/15 revealed the physician encouraged the resident to take control of his/her health and skin care/wound prevention with a high protein diet and using off-loading of pressure points. The note indicated the resident was non-compliant.

Review of a hospital physician progress note dated 3/23/15 revealed the resident was noncompliant.

Review of an ADL report dated 6/12/15-6/18/15 revealed only night shift documented repositioning with a "yes".

Review of the resident's oral intake from 10/1/14-6/18/15 revealed staff did not document

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nutritional supplement intake until 2/9/15. The resident received a supplement 79 out of 387 opportunities.

Observation on 6/17/15 at 11:45 AM revealed the resident's room door closed and several voices coming from inside. At 11:59 AM, the door to the resident's room was open and the resident not inside the room. A Hoyer lift sat inside the room. At 12 PM, the resident sat in the dining room and reported the food was good. The resident received lasagna, green beans, chocolate milk, water, iced coffee, and lettuce salad. The resident fed him/herself and ate everything except 1/2 of the green beans. At 12:15 PM, the resident went outside with staff in his/her wheelchair, the resident sat on a cushion. At 12:30 PM, 12:45 PM, 1 PM, and 1:09 PM the resident remained in the wheelchair, and at 1:09 PM, 3 visitors went in to the resident ' s room. At 1:25 PM, 1:40 PM, 1:55 PM, 2:05 PM, 2:18 PM, 2:35 PM the resident sat in his/her room in his/her wheelchair, he/she had a foot backboard in place with leg separator. At 2:50 PM, the resident's visitors left. At 3:05 PM and 3:20 PM, the resident remained in the same position in the wheelchair in his/her room. The resident wore shoes, but no heel protectors. At 3:38 PM the resident remained in the chair, a time of 3 hours and 39 minutes. During this time, no staff went in to offer repositioning.

Observation on 6/17/15 at 3:38 PM revealed direct care staff A, direct care staff E, and direct care staff F reported the first shift staff reported to them repositioning the resident at 1:30 PM. At 3:44 PM, the resident rested in the bed after staff A, staff E, and staff F lay him/her down with a mechanical lift. Two staff had to assist the resident with bed repositioning. Direct care staff F

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touched each area of redness which revealed the resident had blanchable redness to his/her left buttock, a healed surgical incision, a non-blanchable area of redness approximately 1 inch x 2 inch on his/her right buttocks, and a non-blanchable area to the inner right thigh of the same size. The resident did not have any open areas. Staff F confirmed the area remained red when pressed. The resident reported he/she thought she had been off of his/her bottom at some point since lunch.

Interview with direct care staff A on 6/17/15 at 3:51 PM revealed staff repositioned the resident every 2 hours. Staff A reported the resident notified the staff when he/she needed assistance.

Interview with direct care staff B on 6/18/15 at 11:08 AM revealed the resident required total care for repositioning, transfers, and toileting. Staff B reported the resident did not have any current skin conditions, but had a wound previously and had surgery to have it fixed. Staff B reported he/she repositioned the resident every two hours. Staff B reported the resident was usually just up in his/her chair for meals and when he/she sat in the chair staff B repositioned the resident every 2 hours. Staff B reported he/she repositioned the resident in his/her chair by laying the chair back, then pulling the resident up in the chair or shifting the resident from side to side. Staff B reported during the time the resident had the pressure ulcer he/she repositioned the resident every 2 hours. Staff B reported the resident could stay up in the chair for 2 hours currently, but previously, he/she could only stay up for 30 minutes during the time the resident had the wound.

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Interview with licensed nursing staff C on 6/18/15 at 1:20 PM revealed resident #4 needed total care with transfers and toileting. He/she expected the aides to reposition resident #4 every 2 hours when in bed. Staff C reported the resident was only supposed to be up for about 90 minutes in the chair because of issues with his/her bottom, unless the resident requested to sit up longer, but then he/she had to chart it. Staff C reported resident #4 had a wound on his/her buttocks and he/she had flap surgery then returned from the physician with sitting restrictions. Staff C reported the resident received zinc, a multivitamin, and drank a protein supplement twice a day unless the resident refused. Staff C reported he/she documented the administration of supplements in the electronic MAR (medication administration record)/TAR (treatment administration record). Staff C reported the resident had a stable weight, usually skipped breakfast, but ate lunch and supper well. Staff C confirmed resident #4 lost weight, so the staff added the protein supplements. He/she reported the aides obtained weights on the weekends and the dietary staff and DON (Director of Nursing) reviewed the weights.

Interview with dietary staff D on 6/18/15 at 1:41 PM revealed resident #4 received Special K supplement per the resident ' s request. Staff D reported the nursing staff documented whether or not the residents received or consumed the supplements. Staff D reported the staff reviewed appetites and weights in care plan meetings. He/she reported the dietician looked at weights and made recommendations after weight changes monthly. Staff D reported the resident preferred not to eat breakfast and slept in. He/she reported the resident wanted to lose weight,

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monitored his/her own weight, and very conscious about what he/she ate. Staff D reported he/she tried to encourage protein for the resident especially for the wound healing.

Interview with administrative nursing staff J on 7/14/15 at 2:12 PM revealed staff weighed each resident weekly. Staff J reported resident #4 had been on his/her own weight loss plan for at least 2 years. The resident wanted to lose weight and worked very hard to do it. Staff J reported resident #4 restricted what he/she ate and drank and refused to eat things he/she thought were too high in calories which could cause weight gain. Staff J reported the resident had good understanding about the things he/she should and should not eat to lose weight. Staff J reported the resident lost 20 lbs. in the past 180 days and was ecstatic about it. Staff J reported resident #4 agreed to drink a protein drink to add calories and protein to his/her diet a couple times per day. Staff J reported he/she expected staff to reposition resident #4 every two hours whe he/she lay in bed as the resident had a alternating pressure mattress on his/her bed. Staff J reported the resident had sitting restrictions of being up 3 times per day for 90 minutes at a time, then he/she expected staff to lay the resident back down in bed and off of his/her bottom.

Review of the facility policy for Moving and Positioning Residents, dated 03/2009, revealed residents were to be repositioned using an individualized repositioning schedule determined by the charge nurse on assessment of resident needs, the CNA (Certified Nursing Assistant) documented repositioning on the individual ' s care plan documentation form, and the charge nurse monitored repositioning. Residents in beds,

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F 314	Continued From page 41 wheelchairs, geri chairs, and recliners who were unable to reposition themselves were at risk and were repositioned as scheduled. The facility failed to implement planned interventions for repositioning the resident for the prevention of the re-development of pressure ulcers for resident #4.	F 314		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 36 residents with 6 in the sample. Based on observation, interview, and record review the facility failed to investigate causal factors of falls for 3 of 3 residents sampled for accidents (#1, #2, and #3). The facility also failed to provide adequate supervision and develop and implement effective and appropriate fall prevention interventions to prevent a fall in which resident #1 sustained an ear laceration and required sutures and resident #2 sustained a lip laceration and required sutures. The facility also failed to store chemicals securely to prevent accidents. Findings included:	F 323		

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- Review of resident #1's annual MDS (Minimum Data Set) assessment dated 10/6/14 revealed a BIMS (Brief Interview for Mental Status) score of 11, indicating moderate cognitive impairment. The resident required limited assistance of 1 staff for transfers and toileting. He/she was independent with walking in the room and corridor, and locomotion on the unit. The resident had frequent urinary incontinence, occasional bowel incontinence and currently participated in a toileting program. The resident had one non-injury fall since the previous quarterly assessment.

Review of the Fall CAA (Care Area Assessment) dated 10/13/14 revealed resident #1 had a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion) and bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods). Resident #1 fell on 10/5/14 when he/she slid to the floor from the recliner. Resident #1 ambulated by him/herself without supervision within the unit and with supervision outside the unit. He/she had a slightly shuffled gait and could fully bear weight. The resident was oriented to his/her surroundings and aware of important areas within the unit. He/she needed cues and reminders as well as limited assistance with ADL (activities of daily living) cares. As his/her dementia progressed, his/her physical functioning continued to decline.

Review of the ADL Functional/Rehabilitation CAA dated 10/13/14 revealed resident #1 had frequent bowel and bladder incontinence. Resident #1 knew where the bathrooms were, but staff needed to remind him/her to use the bathroom and provide incontinent hygiene as needed. The

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resident wore adult incontinence products and if he/she took it off, he/she did not always put a clean one on.

Review of a 4/3/15 quarterly MDS assessment revealed a BIMS score of 3, indicating severe cognitive impairment. Resident #1 required limited assistance of 1 staff for bed mobility, transfers, walking in the room and corridor, locomotion on the unit, and he/she required extensive assistance with toileting and personal grooming. The resident had one non-injury fall and one minor injury fall since the previous assessment.

Review of resident #1's Fall Risk assessments revealed:
*1/14/15-a score of 15, with over 9 indicating risk for falls
*4/8/15-a score of 19
*5/7/15-a score of 17

Review of resident #1's care plan, initiated 10/12/12, revealed the resident had a history of falls. Interventions directed staff to:
*Monitor for orthostatic hypotension (a form of low blood pressure that occurred from standing up from sitting or lying down)
*Take the resident's blood pressure prior to administering blood pressure medications daily.
*Provide the resident a night light in his/her room
*Sit with the resident and help him/her get back to sleep when he/she woke up unexpectedly
*Keep the call light within reach
*Provide activities throughout the day
*Report all falls with injury to the physician immediately
*Encourage the resident to wear shoes for ambulation

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*Monitor and decrease the resident's psychotropic medications per facility policy
*Remove obstacles from the resident's path
*Complete a fall risk assessment every 3 months. If the fall risk increased, staff were to implement new interventions to prevent falls.
Staff revised the care plan on:
*10/6/14 -assist the resident to an upright position in his/her recliner in the event he/she began to slide down.
*11/20/14- the resident experienced a fall, staff were to assist resident #1 with ambulation to and from meals.
*12/4/14- the staff found the resident on the floor in another resident's room. Staff were to re-direct the resident out of other resident's rooms and provide appropriate supervision.
* 5/8/15- staff were to ensure:
1. Resident #1's bed alarm and chair alarm worked at all times.
2. A clear visual path from the dining room to the resident's recliner.
3. Use of a chair alarm in the recliner and dining chair.
4. Use of a halo bed buddy system for positioning in bed.
5. The resident had continuous oxygen via nasal cannula to maintain oxygen saturations above 90%.
6. To provide assistance to the resident with a gait belt for ambulation.
7. To toilet the resident every 1.5-2 hours.
8. To provide activities for the resident when he/she got up at night.
The resident's care plan did not address the injury to the resident's ear or the care/monitoring it required after a fall on 4/28/15.

Review of a Fall Investigation dated 1/16/15 at

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1:10 AM revealed staff found resident #1 after he/she fell in his/her room while attempting to get out of bed unassisted. The investigation revealed the resident had a recent severe upper respiratory infection, was alert, confused, wandered at the time of the fall, and had a decrease in orientation in the previous 7 days. Per the investigation the resident called for help, but the call light was not in reach. The resident toileted last at 12:00 AM and ate last at 7:00 PM. The investigation indicated no problems with the resident's environmental factors. Per the investigation staff implemented a new intervention to show the resident where his/her room was and ask the resident to ring for assistance. The Fall Investigation revealed administrative nurse J reviewed the investigation on 2/9/15 (3 ½ weeks later) and he/she recommended a bed alarm to the resident's bed, continue other fall precautions, and consistent reminders to ring and wait for assistance. Staff failed to review and revise and add an intervention to the resident's care plan to prevent further falls. The investigation did not identify the root cause of the fall.

Review of a Fall Investigation dated 1/16/15 at 9:30 PM (a second fall on that day) revealed staff found resident #1 on the floor in the hallway by the fire doors. The resident stated he/she just slipped hit his/her head. The investigation did not include information relating to the root cause of the fall. The Fall Investigation revealed administrative nurse J reviewed the investigation on 2/9/15 (3 ½ weeks later) with a recommendation to routinely check on the resident when he/she was in his/her room to prevent falls. Staff failed to add the intervention to the care plan.

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Review of a Fall Investigation dated 3/14/15 at 9:00 PM revealed staff lowered resident #1 to the floor during ambulation because the resident felt weak and dizzy. Staff determined the cause of the fall was due to his/her cancer treatments and weekly chemotherapy. The investigation revealed the resident had become weaker and less steady and the resident required staff assistance for ambulation for safety at that time. The Fall Investigation revealed administrative nurse J reviewed the investigation on 4/30/15 (about a month and ½ later) and made recommendations to ambulate with the resident using 2 staff if the resident felt weak or dizzy or put the resident in the wheelchair if he/she appeared too weak to ambulate distances. Staff failed to update the care plan to include the entire recommendation, and only added staff were to ambulate with the resident with a gait belt when he/she felt dizzy.

Review of a Fall Investigation dated 4/3/15 at 5:20 PM revealed staff lowered resident #1 to the floor during an assisted transfer/ambulation. Per the investigation the resident stated he/she was dizzy at the time of the fall. The investigation indicated the resident received chemotherapy treatments every 2 weeks during that time, had become weaker, and required staff assistance at times for safety. The investigation revealed the resident did not have a gait belt in place. The Fall Investigation revealed administrative nurse J reviewed the investigation on 4/13/15 (10 days later) and recommended for staff to use a gait belt with the resident while up ambulating, especially if the resident felt weak or just finished chemotherapy. The investigation did not identify possible causal factors of the resident's fall.

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Review of a Fall Investigation dated 4/20/15 at 6:00 AM revealed staff found resident #1 on the floor by his/her bed on his/her buttocks. Per the investigation the resident stated he/she was trying to get up, but did not indicate why the resident tried to get up. The investigation indicated the resident did not ring his/her call light. He/she had a diagnosis of dementia with long and short term memory loss, and needed stand by assistance from staff when ambulating due to weakness and dizziness. The investigation reported the resident tried to be independent and not ask for assistance from staff. The investigation did not include information relating to the root cause of the fall. The Fall Investigation revealed administrative nurse J reviewed the investigation on 5/1/15 (11 days later) and recommended the bed in low position and bed alarm in place at all times when the resident rested in bed. Staff failed to include an intervention related to the position of the bed when the resident lay in bed as recommended in the investigation. Instead staff added on 4/23/15 (3 days later), for staff to use a bed alarm to alert staff when the resident tried to get up.

Review of a Fall Investigation dated 4/28/15 at 3:30 PM revealed staff found resident #1 on the floor in another resident's bathroom with a laceration and minor bleeding to his/her left ear. Per the investigation the resident had bowel and bladder incontinence at the time of the fall. The resident reported he/she fell and hit his/her ear on the toilet. Staff sent the resident to the ER (emergency room) for sutures and examination. The Fall Investigation revealed administrative nurse J reviewed the investigation on 5/7/15 (9 days later) and entered the following findings and recommendations: The resident had a decline in

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condition due to chemotherapy and cancer. A few months prior, the resident ambulated independently without devices, but at the time of the fall the resident required assistance of 1 or 2 staff and a gait belt for ambulation depending on his/her steadiness. The resident had not attempted to get up unassisted for months. The resident left the SCU (special care unit) living room area independently without assistance from staff. The resident fell in another resident's bathroom while attempting to toilet him/herself. The resident reported to staff he/she needed to use the bathroom when staff found him/her on the floor. The resident could not tell staff how he/she fell or what he/she hit his/her ear on in the fall. The CNAs (Certified Nursing Assistant) assigned to the SCU were in rooms with other residents when the fall occurred. The programmers were performing activities with other residents when the resident left the common area. The nurse had his/her medication cart parked on the southwest side of the living room area beside the resident's recliner, which made the recliners in the living room difficult to visualize from the dining room area. The SCU director was in his/her office when the fall occurred. Interventions to prevent the resident from falling: Chair alarm in the chair at all times, bed alarm in place when in bed, the medication cart would not be parked in a way to block the view from the dining room to the living room, staff were to toilet resident #1 every 1.5-2 hours with prompting to get up and go to the restroom by staff, and staff were to monitor the resident while up in the recliner at all times. Staff updated the care plan with the chair alarm only on 4/29/15.

Review of a progress note dated 4/28/15 at 4:48 PM revealed staff found resident #1 in another

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resident's room. Per the note the resident had an incontinent bowel and bladder episode and fell. The resident stated he/she hit his/her left ear on the toilet. Staff indicated in the note that resident #1 had bleeding and a laceration to the top part of his/her ear, staff cleaned the resident up, and sent the resident to the ER (emergency room).

Review of the ER report dated 4/28/15 revealed the resident presented with a laceration to his/her left ear. The resident could not tell staff how it happened. The report indicated the resident had a 4.5 cm (centimeter) laceration to the left ear that involved underlying cartilage. The physician noted he/she sutured approximately a 7 cm total area.

Observation on 4/30/15 at 4:44 PM revealed resident #1 lay in a recliner in the dining room with the foot rest partially up. The resident had tennis shoes on and his/her eyes were closed. His/her walker sat folded up and rested on the wall behind the recliner. A personal alarm box sat next to the resident in the chair. The resident's left ear had a laceration across the ear.

No further observations were made due to the resident discharged from the facility.

Interview with direct care staff H on 4/30/15 at 4:40 PM revealed normally 2 programmers, who sat with the residents and provided activities, and 2 CNAs (certified nurse aides) were staffed during the week and the weekends. Staff H reported a nurse was not scheduled on the SCU. He/she revealed resident #1 fell and his/her ear. Staff H reported he/she did not really know much about the resident's fall. He/she stated he/she cared for 9 residents on the SCU.

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Interview with direct care staff G on 6/18/15 at 11:34 AM revealed he/she visualized resident #1 ' s ear after the fall and it had been detached with cartilage exposed. Staff G confirmed the resident needed stiches to his/her ear. Staff G reported resident #1 normally walked alone but had an unsteady gait at times.

Interview with licensed nursing staff I on 6/18/15 at 1:36 PM revealed resident #1 needed some assistance getting up on occasion. Staff I reported resident #1 walked on his/her own, staff assisted the resident to the bathroom, but the resident spent most of his/her time in the day room. Staff I reported the resident had a steady gait, shuffled his/her feet a little, and walked slowly. Staff I reported resident #1 had an occasional fall. He/she reported the resident began to have more frequent falls when the resident began to have more exhaustion and weakness. Staff I confirmed the last fall the resident had, the resident sustained an injury to his/her ear.

Interview with administrative nursing staff J on 7/14/15 at 2:12 PM revealed staff completed fall investigations through the facility's risk management process to determine the best possible course of action to prevent another fall. He/she reported fall interventions were required to be in place immediately following any fall to prevent another fall. Staff J stated he/she worked with the charge nurses and the MDS Coordinator to determine appropriate fall interventions following any resident fall. Staff J reported the fall investigation process could take time, so the nursing staff had to intervene as soon as a fall happened to prevent another fall. He/she

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reported he/she normally completed fall investigations, then the facility risk management team reviewed them and sometimes had further suggestions for fall interventions. Staff J reported resident #1 began requiring stand-by assistance with ambulation due to dizziness and weakness. Staff J reported resident #1 had 5 falls between October 2014 and January 2015. He/she stated 1 of those falls happened when the resident repositioned him/herself in the recliner and slid off the end, 2 of the falls occurred when the resident attempted to get out of his/her recliner unassisted, a fourth fall happened while the resident moved from his/her chair in the dining room and got his/her foot tangled in the leg of it, and the fifth fall happened while the resident ambulated independently in the corridor outside the SCU common room where the resident stated he/she slipped and fell. Staff J reported interventions following falls included: increased toileting assistance (reminders, cuing, and personal hygiene assist), redirection when confused and lost in SCU, assistance for seating in the dining room, and increased times assisted to the toilet (every 1.5 hours while awake). Staff J reported all of the falls before March 2015 were during independent ambulation or transfer. He/she stated in March and April 2015, following chemotherapy, the resident had 2 falls where staff lowered the resident to the floor during transfer or ambulation. Staff J stated the resident had dizziness and weakness causing the resident to be unable to stand without support. Staff J revealed interventions following those falls included: 2 person assisted transfer and ambulation. He/she reported on 4/20/15, staff found resident #1 on the floor beside his/her bed after attempting to get up without assistance. Staff J reported staff applied a bed alarm to the

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resident's bed so staff knew when the resident attempted to get up without assistance. Staff J reported on 4/28/15 resident #1 sat in the SCU living room/common area in the resident's recliner. He/she reported resident #1 got up out of the recliner independently and started down the main SCU corridor looking for his/her room and a bathroom. Staff J reported a CNA found the resident on the floor in the bathroom of another resident's room. He/she reported staff were unable to determine how the fall happened due to resident #1's long and short term memory loss related to the resident's diagnosis of dementia. Staff J reported the CNAs assigned to the SCU were in other rooms caring for residents at the time of resident #1's fall. Staff J reported interventions implemented following the fall included: a chair alarm in place at all times while the resident sat in the recliner in the SCU living room area, a bed alarm in place at all times while in bed, the CMA (Certified Medication Aide) and nurses were to place the medication cart on the north side of the living room area so the programming staff had a direct visual of the residents in their recliners in the SCU living room area, toilet resident #1 per his/her toileting plan every 1.5-2 hours with prompting to get up and go to the restroom by staff, and monitor the resident by nursing staff at all times while up in recliner. He/she reported staff were not to leave the SCU unattended without staff observing the activities of residents.

Review of the facility's policy for Fall Prevention, dated 11/2001, revealed the nurse needed to individualize the resident ' s care plan based on the fall assessment and interventions chosen to prevent a fall from occurring. If a resident fell the staff were to: assess the resident for injury;

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complete a progress note regarding the fall, any injuries sustained, and new interventions placed to prevent another fall; update the care plan to reflect new interventions based on the fall; notify the resident's physician and family; complete a Fall Assessment and Investigation Report; and complete the appropriate documentation following the Fall Work Flow Plan.

The facility failed to identify the root cause of falls, complete fall investigations in a timely manner, and provide adequate supervision and appropriate and effective interventions to prevent falls for resident #1 who fell and sustained a left ear laceration that required sutures.

- Review of resident #2's significant change MDS (Minimum Data Set) dated 2/9/15 revealed a BIMS (Brief Interview for Mental Status) score of 0, indicating severe cognitive impairment. The resident required extensive assistance of 2 or more staff for bed mobility, transfers, and toileting. The resident had frequent bowel and bladder incontinence and had a toileting program. The resident did not experience falls after admission.

Review of the Fall CAA (Care Area Assessment) dated 2/17/15 revealed the resident had short and long-term memory loss with confusion. The resident fell on 12/20/14 when staff assisted him/her from the chair. The resident depended on staff for his/her ADL (activities of daily living) care. The resident recently hospitalized with pneumonia and his/her physical functioning declined since his/her return. The resident needed assistance with transfers and ambulation, cues and reminders, and needed more help at meal times.

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Review of a quarterly MDS dated 5/15/15 revealed the resident had a short and long-term memory problem and severely impaired cognitive skills for daily decision making. The resident required extensive assistance of 2 or more staff for: bed mobility, transfers, walking in the room and corridor, toileting, and personal hygiene. The resident had one minor injury fall and one fall without injury.

Review of the resident's Fall Risk assessments revealed scores of:
*11/1/14-10, with 9 or above indicating the resident had increased risk of falls
*2/24/15-18
*4/28/15 and 5/2/15- 24

Review of the resident's care plan, last reviewed by staff on 5/13/15, revealed interventions directed staff to:
*2/10/14: walk with the resident if he/she had anxiety and wanted to walk, monitor the resident's whereabouts at all times, respond to safety alarms immediately, keep the resident's call light in reach, and toilet the resident every 2 hours during the day, before and after meals, and 3-4 times at night.
*2/14/14: be aware the resident refused to call for assistance with transfers and ambulation, keep areas free of clutter, and complete a fall assessment every 3 months.
*Interventions dated 12/20/14 revealed the resident fell and to assess for dizziness or blood loss with cares and assist with 1 staff for ambulation, sitting, or lying down PRN (as needed).
*2/18/15: provide assistance of 2 staff with transfers and at times use the stand-up lift

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(mechanical lifting/transfer device), keep furniture in the same place in his/her room, escort the resident to meals and other activities, and leave the resident in a safe position and return at a later time if the resident became upset with transfers.
*3/26/15: use a bed alarm to alert staff if the resident got out of bed unassisted.
*4/26/15: the resident fell. The care plan did not alert staff to the resident's injury that occurred with the fall or the care of the injury. Staff failed to review/revise the care plan with an intervention to prevent further falls until 4/29/15.
*4/29/15: monitor and redirect the resident if he/she left the locked unit living room area without staff.
*4/30/15: use a chair alarm for the resident.
*5/8/15: the resident fell and staff were to check the resident hourly and re-orient the resident to his/her environment.

Review of a fall investigation dated 12/20/14 at 1:20 PM revealed the resident fell while attempting to sit in a recliner in the SCU (special care unit) living room area. The resident normally ambulated independently without assistive devices without a gait belt. Staff reported the resident just lost his/her balance while sitting and fell to the side. Normally the resident could transfer him/herself safely. Staff obtained a urinalysis and found the resident had a urinary tract infection and treated the resident for it. The fall investigation did not include investigation into other causes or contributing factors of the resident's fall. Staff marked the investigation complete on 12/30/14, 10 days after the fall.

Review of a fall investigation dated 4/26/15 at 5:35 PM revealed staff found the resident on the floor at the north end of the hall after a fall when

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he/she attempted to get up without assistance. The resident required staff assistance with all transfers and ambulation for safety. The wheelchair sat beside the resident at the time staff found him/her. The investigation revealed staff did not see the resident leave the common area prior to the fall, the resident needed close monitoring, and should not be wandering in the halls outside the locked unit living/dining room without supervision as he/she had no safety awareness. Administrative nurse J reviewed the incident on 5/1/15 (5 days later) and recommended the resident be supervised at all times when not in the living/dining room area of the locked unit, except when in bed. Staff placed a chair alarm on the resident's wheelchair. The investigation also revealed the resident sustained injuries to his/her upper lip and left palm that required stitches. The investigation did not include causal factors or identify the root cause of the fall.

Review of a fall investigation dated 5/8/15 at 10:11 AM revealed staff heard the resident's bed alarm and found the resident on the floor sitting next to his/her bed. Administrative nurse J reviewed the incident on 5/26/15 (2 ½ weeks later) and recommended routine observation checks of the resident while in bed, keep the bed in the low position, and keep a fall mat on the floor beside the bed. The investigation did not include causal factors or identify the root cause of the fall.

Observation on 4/30/15 at 4:49 PM revealed the resident lay in a recliner in the living area. The resident's foot rest was in the up position and the resident wore house slippers. The resident's left hand and wrist had purplish/green bruising on the

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top of the hand and the palm. The resident had 1/2 a tennis ball sized bump to his/her left forehead. The resident also had a personal pressure alarm in place. No sutures were visible.

Observation on 6/17/15 at 11:53 AM revealed the resident sat in a chair in the living room area with his/her feet raised. The resident wore a gait belt and house slippers. He/she did not have any visable bruises. The resident had a 1/2 tennis ball sized lump to his/her left forehead. The resident had his/her eyes closed and snored. He/she had a personal pressure alarm in place.

Interview with direct care staff G on 6/18/15 at 11:35 AM revealed the resident stood up and walked with 1-2 staff. He/she reported at times the staff used a sit-to-stand lift. Staff G reported the resident used a bed alarm and he/she did not know of any falls for the resident.

Interview with direct care staff H on 6/18/15 at 2:26 PM revealed the resident's gait varied depending on the day. He/she reported the resident had a chair alarm in place and staff constantly checked on the resident. He/she reported the resident never left the living room unattended. He/she also reported he/she was present on 4/26/15 when the resident fell. Staff H reported he/she had been setting up tables when he/she saw the resident down the hall on the floor. Staff H reported he/she did not see the resident's wheelchair that day.

Interview with licensed nursing staff I on 6/18/15 at 1:57 PM revealed the resident required quite a bit of assistance. Staff I reported normally the resident could not get up and walk on his/her own. He/she reported the resident's gait varied

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depending on the day, but the resident usually needed assistance of 1 staff for ambulation. Staff I reported the resident was a fall risk because the resident had times of confusion and agitation and the resident could not express him/herself. Staff I reported the resident tried to get up by him/herself often at times. He/she reported the resident fell around the end of April 2015 and had a laceration to his/her lip that required stitches or sutures.

Interview with administrative nursing staff J on 7/14/15 at 2:12 PM revealed resident #2 had 2 falls between 12/20/14 and 4/26/15. Staff J reported the physician decreased the resident's psychotropic medications by stopping his/her Geodon and Exelon patch in January and February because his/her behaviors and activity level had changed. Staff J reported the resident started to become more active and attempted to ambulate on his/her own. Staff J reported the resident was very unsteady on his/her feet, so staff were assisting him/her with ambulation whenever he/she attempted it. Staff J reported the resident could use his/her wheelchair for mobility within the SCU. Staff J reported the resident fell on 12/20/14 during a staff assisted transfer and ambulation when resident #2 lost his/her balance while attempting to sit down in a recliner in the common area. Staff were unable to hold him/her up, per staff J report, even using the gait belt due to the resident's large size. Staff J reported when the resident fell on 4/26/15, he/she propelled him/herself around the SCU common area and corridor in his/her wheelchair when he/she attempted to stand up from the wheelchair in the corridor and fell. Staff J confirmed staff did not witness the fall but the resident told staff he/she fell standing up out of

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his/her wheelchair. Staff J reported the resident had not attempted to get out of his/her recliner or wheelchair without assistance prior to that fall and normally asked for assistance and waited for staff to help him/her. Staff J reported the resident did not have a chronic history of falling.

Review of the facility's policy for Fall Prevention, dated 11/2001, revealed the nurse needed to individualize the resident's care plan based on the fall assessment and interventions chosen to prevent a fall from occurring. If a resident fell the staff were to: assess the resident for injury; complete a progress note regarding the fall, any injuries sustained, and new interventions placed to prevent another fall; update the care plan to reflect new interventions based on the fall; notify the resident's physician and family; complete a Fall Assessment and Investigation Report; and complete the appropriate documentation following the Fall Work Flow Plan.

The facility failed to investigate causal factors of falls and provide adequate supervision to prevent further falls from occurring for resident #2, who fell and sustained a laceration requiring stitches to his/her upper lip.

- Review of resident #3 ' s signed physician orders dated 1/15/15 revealed the following diagnoses: hip fracture (broken hip), atrial fibrillation (rapid, irregular heart beat), left knee osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), hypertension (high blood pressure), urinary incontinence and CVA (Cerebrovascular accident - the sudden death of brain cells due to lack of oxygen when the blood flow to the brain is impaired by blockage or rupture of an artery to

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F 323	Continued From page 60 the brain). Review of an admission MDS (Minimum Data Set 3.0, a required assessment) dated 1/8/15 revealed BIMS (Brief Interview for Mental Status) of 7, indicating severe cognitive impairment. The resident required extensive assistance of two or more staff for bed mobility, transfers, toileting, and personal hygiene. The resident was frequently incontinent of bladder and on a toileting program. The resident had a fall in the 2-6 months prior to admission with a fracture related to a fall during that time. The resident had one minor injury fall since admission. Review of the Fall CAA (Care Area Assessment) dated 1/9/15 revealed the resident had diagnoses of: status post ORIF (open reduction and internal fixation- a surgical procedure to repair a hip fracture)of the right hip, CVA, depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), atrial fibrillation, osteoarthritis, hypertension, and dementia (progressive mental disorder characterized by failing memory, confusion). The resident was alert and oriented to self and family. The resident was dependent on staff for his/her ADL (activities of daily living) cares, with cues and reminders. The resident used a stand up lift (mechanical lifting/transferring device) with 2 staff due to weakness and pain in both lower extremities. The resident could use his/her call light for assistance and to make his/her want/needs known. The resident did not generally attempt to get up from bed or the chair without assistance. When asked if he/she could stand up and walk without assistance he/she replied no.	F 323		

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Review of the ADL CAA dated 1/9/15 revealed the resident could alert staff of the need to use the toilet, usually had urinary incontinence, dribbled urine as soon as staff removed his/her brief, and then finished in the toilet.

Review of a quarterly MDS assessment dated 4/10/15 revealed a BIMS score of 3, indicating severe cognitive impairment. The resident required extensive assistance of two or more staff for bed mobility, transfers, toileting, and personal hygiene and was occasionally incontinent of bladder. The resident fell in the 2-6 months prior to admission with a hip fracture and did not fall since the previous assessment.

Review of the care plan last reviewed revealed the following interventions with implementation dated:
12/29/14:
· Offer and assist the resident to toilet every 2 hours and as needed,
· Encourage resident to get out of bed daily as tolerated.
1/12/15:
· Ensure Call light in reach. Remind what it is and what it was for,
· Offer to toilet the resident as he/she had occasional bowel and/or bladder incontinence. Check every 2 hours and PRN.
· Transfer with a stand up lift with 2 staff.
· Provide assistance of one staff f for bed mobility.
1/13/15:
· Provide assistance of one or two staff for transfers and ambulation.
· Complete fall risk assessment every 3 months.
· Remind the resident to wait for assistance

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from staff.
· Consult physical therapy to help improve mobility
· Use bed alarm and ensure it worked properly, Place the bed against the wall to define parameters
1/23/15:
· Use a fall mat on the floor next to the bed when the resident lay in bed.

Review of the fall risk assessments revealed the following scores, with a score above 9 indicating the resident had an increased risk for falls:
12/29/14 and 3/10/15- 26
3/20/15- 24
4/10/15- 26

Review of a fall investigation dated 1/3/15 revealed staff found the resident lying on the floor on his/her right side beside his/her bed facing the window after he/she called for help from nursing staff. The resident had a bed with bolstered (raised) sides and the call light was in reach. The resident stated he/she attempted to get up and go to the bathroom. The resident did not have a history of getting up without assistance. Administrative nursing staff J reviewed the incident on 1/21/15 (2 ½ weeks after the fall) and made recommendations to use a bed alarm on the bed, a fall mat on the floor beside the bed, and use the established toileting plan for the resident.

Review of the resident's progress notes revealed:
1/3/15- revealed staff sent the resident to the ER (emergency room) for evaluation and x-rays of the right shoulder and right hip to rule out fracture after falling out of bed at 6:15 AM. Results showed no broken bones or cranial (brain)

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bleeds. Staff moved the resident ' s bed to a safe location and placed a bed alarm on his/her bed to hopefully prevent another fall.

Observation at 12:36 PM direct care staff L and licensed nursing staff C transferred the resident onto the toilet using a sit-to-stand lift. The resident requested to sit a while and Staff L gave the resident his/her call light, closed the door and left down the hall.

Observation on 6/17/15 at 2:00 PM, 2:15 PM, 2:30 PM, 2:45 PM, and 3 PM revealed the resident sat in his/her wheelchair on a cushion. At 3:15 PM, the door was closed and staff voices came from inside. At 3:30 PM, the resident sat in the recliner on a cushion, pillows under his/her legs with feet elevated and shoes on.

Interview with the resident on 6/17/15 at 11:30 AM revealed the staff used a lift to transfer him/her. The resident stated he/she fell once, but just slipped out of bed and had a mat there now.

Interview with direct care staff B on 6/18/15 at 11:14 AM revealed the staff provided total assist of 2 staff for bed mobility, used a stand up lift for transfers or 2 person staff with gait belt, the resident worked with therapy for walking, and the resident had urinary incontinence most of the time. Staff B stated the resident was a fall risk, but had not fallen in a while. Staff B stated staff placed a mat on the floor next to the bed and the resident called for help and did not try to get out of bed on his/her own.

An interview on 6/18/15 at 2:34 PM with direct care staff M revealed the resident did not experience falls recently and the resident did not

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try to get up on his/her own. Staff M stated the resident was pretty good about waiting for staff to come and help him/her.

Interview with licensed nursing staff C on 6/18/15 at 1:20 PM revealed staff used a sit-to stand lift for transfers.

Interview with administrative nursing staff J on 7/14/15 at 2:12 PM revealed the following about fall investigations:

· Fall investigations were completed through the facilities risk management process to determine any negligence or abuse involved in the fall and to determine the best possible course of action to prevent another fall.

· Fall interventions were required to be in place immediately following any fall, to prevent another fall.

· The charge nurses, MDS Coordinator, and staff J worked together to determine appropriate fall interventions following any fall. Once staff completed the fall investigation, the risk management team could have further suggestions for fall interventions. The process could take some time, so the nursing staff had to intervene as soon as a fall happened to prevent another fall.

· Fall investigations were normally completed by staff J and the facility risk management team reviewed every investigation.

Review of the facility ' s policy for Fall Prevention, dated 11/2001, revealed the nurse needed to individualize the resident ' s care plan based on the fall assessment and interventions chosen to prevent a fall from occurring. If a resident fell the staff were to: assess the resident for injury; complete a progress note regarding the fall, any

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injuries sustained, and new interventions placed to prevent another fall; update the care plan to reflect new interventions based on the fall; notify the resident ' s physician and family; complete a Fall Assessment and Investigation Report; and complete the appropriate documentation following the Fall Work Flow Plan.

Staff failed to investigate falls in a timely manner to prevent further falls for resident #3.

- During an initial tour of the facility on 4/30/15 at 3:15 PM revealed the following chemicals within resident reach:
Activity room:
*Large aerosol container of air freshener
*6 oz. (ounce) container of nail polish remover approximately ½ full
*1 gallon container of Fertilome liquid fertilizer
*8 oz. container of 100% acetone approximately ½ full

An unlocked, unattended office with the door open attached to the activity room:
*6 full 10 oz. containers of nail polish remover
*6 full cans of electronics duster

An unlocked office for social services/medical records:
NABC brand surface disinfecting wipes on a cabinet.

Nourishment room in an unlocked bottom cabinet:
NABC brand surface disinfecting wipes

All chemicals observed had warning labels to keep out of reach of children.

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F 323	Continued From page 66 Interview with administrative nursing staff J on 4/30/15 at 5:20 PM revealed he/she knew the chemicals were to be locked up and not accessible to the residents. Review of the facility policy for Cleaning Supplies and Chemical Storage, revised 6/23/14, revealed the facility would ensure the safety of residents by assuring all chemical and cleaning supplies were kept in locked cabinets in non-resident areas. The facility failed to store potentially hazardous chemical solutions in the resident environment.	F 323		
F 325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: The facility reported a census of 36 residents with 6 residents in the sample. Based on observation, interview, and record review the facility failed to develop and implement effective interventions to prevent weight loss for 2 of 3 residents reviewed for weight loss. (#4 and #5) Resident #5 sustained significant weight loss of	F 325		

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9.3% in a little over a month. The facility also failed to collaborate with resident #4's physician to develop a safe weight loss plan for him/her.

Findings included:

- Review of #5's physician signed patient summary from the hospital dated 1/16/15 revealed a diagnosis of anemia (condition without enough healthy red blood cells to carry adequate oxygen to body tissues).

Review of an admission MDS (minimum data set) dated 12/22/14 revealed the resident had short and long-term memory problems and severely impaired cognitive skills for daily decision making. The resident did not exhibit rejection of care. The resident required limited assistance of one staff for walking in the room and corridor, extensive assistance of one staff for transfers, and supervision with setup help for eating. The resident did not have any oral, dental or swallowing problems and had not experienced weight loss.

Review of the Pressure Ulcer CAA (care area assessment) dated 12/23/15 revealed the resident had a diagnosis of dementia (progressive mental disorder characterized by failing memory and confusion), mood disorder (category of mental health problem including feelings of sadness, helplessness, guilt, wanting to die were more intense and persistent than what may normally be felt from time to time), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and agitation. The resident had short and long-term memory loss with confusion. The resident depended on staff for limited to

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extensive assistance with his/her ADL (activities of daily living) cares, along with cues and reminders. The resident had a good appetite and needed setup assistance with meals and fluids.

Review of a quarterly MDS dated 3/25/15 revealed a BIMS (brief interview for mental status) score of 0, indicating severe cognitive impairment. The resident did not exhibit rejection of care. The resident required extensive assistance of two staff for transfers, and extensive assistance of one staff for eating. The resident did not walk. The resident did not have any oral, dental or swallowing problems and had not experienced weight loss.

Review of resident #5's care plan, last reviewed 6/17/15, revealed interventions directed staff to:
12/16/14:
· Weigh weekly and monitor for weight loss
· Provide encouragement for eating.
· Provide a regular diet.
· Monitor food intake at meals and snacks.
· Encourage to eat at least 75% of each meal
2/24/15:
· Provide a supplement of choice 4 oz. (ounces) TID (three times a day) and encourage him/her to drink it. (3/24/15- revised from 4 oz. to 8 oz.)
6/17/15:
· Get the resident up last for meals and lay him/her down first after meals.
The facility failed to implement additional interventions to prevent weight loss from 3/24/15-6/17/15, even though the resident's weight continued to decline.

Review of the resident's lab reports revealed:
12/12/14- Albumin (blood test used to measure

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the amount of protein in the blood, used in part to determine a person's nutritional status) 3.2 grams per deciliter (g/dL) with the normal range of 3.5-4.8 g/dL.
2/6/15- Albumin 3 g/dL (low)
3/20/15- Pre-albumin (blood test used to determine nutritional status) 17mg/dL (milligrams per deciliter) with the normal range of 18 mg/dL -38 mg/dL.

Review of the resident's weights revealed:
12/12/14- 120.2 lbs. (pounds)
12/30/14- 123.4 lbs.
In the hospital from 1/9/15 for a fever of 104 degrees Fahrenheit until1/16/15 when he/she returned on antibiotics for a urinary tract infection per the notes listed below.
1/16/15- 126.4 lbs.
1/21/15- 122.2 lbs.
1/29/15- 120.6 lbs.
2/11/15- 114.4 lbs.
2/20/15- 114.6 lbs. (a loss of 11.8 lbs. from 1/16/15-2/20/15 or 9.3% of the resident's body weight)
In the hospital from 3/9/15-3/13/15 with a non-productive cough and diminished lung sounds per a note listed below.
3/20/15- 114.3 lbs.
3/30/15- 110 lbs.
4/8/15- 109.8 lbs.
4/14/15 and 4/27/15- 107.8 lbs.
5/13/15- 108.2 lbs.
5/22/15- 111.2 lbs.
6/3/15- 107.8 lbs.
6/11/15- 105.4 lbs. (a loss of 4.6 lbs. from 3/30/15- 6/11/15 or 4.2% of the resident's body weight)

Review of the resident's progress notes revealed:

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12/12/14- Physician note- The resident received a regular diet. A review of the resident's symptoms revealed a change in appetite, anorexia (lack or loss of appetite), and not eating well. The resident weighed 120.2 lbs. and the physician planned for him/her not to have any significant weight loss.
1/9/15- Staff sent the resident to the hospital, where he/she admitted, with a fever of 104 degrees Fahrenheit. Staff did not note any edema (fluid retention in the tissues)
1/16/15- The resident re-admitted to the facility with antibiotics for a urinary tract infection. Staff did not note any edema.
1/20/15- The resident ate and drank well.
1/22/15- Dietary note by the dietician- The resident weighed 122 lbs. and received a regular diet. The resident usually ate well for the first couple of bites of meals but lately had refused dinner. The dietician recommended offering supplements when the resident refused to eat.
2/20/15- Staff received an order for a supplement of the resident's choice TID (three times a day) 4 oz. (ounces) with meals and to check the resident ' s pre-albumin in 1 month.
2/21/15- Physician progress note- The resident still did not eat well and had a 9% weight loss in the previous 30 days. Assessment revealed malnutrition with weight loss. Supplements with meals were to be added and staff were to encourage oral intake at meals.
3/9/15- The resident admitted to the hospital for observation with a non-productive cough and diminished lung sounds.
3/14/15-Re-admitted the resident to the facility on 3/13/15. The resident ate and drank well.
3/14/15- Dietary note by the dietician- The resident weighed 114.6 lbs. with a 9.19% weight loss over the previous month. The resident received a regular diet with a 4 oz. supplement of

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choice at meals, which was recently added. The resident had an intake of 25-50% since readmission from the hospital and received calcium with vitamin D. The dietician recommended to monitor oral intake and weight status.
3/15/15- The resident ate well that morning.
3/24/15-The resident was not eating well. Staff faxed the physician to possibly increase his/her supplements.
4/4/15- The resident drank some at supper and then refused anymore liquids. Continue to offer fluids.
4/10/15- Physician note- The resident's recent (3/20/15) pre-albumin was down at 17 mg/dL and the resident started supplements TID. The physician's assessment included malnutrition with weight loss. The physician planned to have staff encourage the resident to eat.
5/27/15- Order received to start vitamin C and zinc to promote wound healing daily.
6/9/15- Dietary note by the dietician- The resident weighted 107.8 lbs. and had experienced a 10.32% weight loss in the past 6 months which was considered severe. The resident received a regular diet with intake of 25-75% at most meals. The resident was previously on a supplement, but the dietician did not know if the resident took it. The resident received calcium with vitamin D, vitamin C, and zinc. The dietician recommended to add supplements if the resident accepted.
6/16/15- The resident's weight dropped 12.31 % in 6 months and he/she weighed 105 lbs. The resident's family member reported to staff that was a normal weight for the resident. Staff sent the physician a fax requesting Ensure 4 oz. with meals.
6/17/15- Staff received an order to recheck the resident's albumin and weight loss. Administer

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Arginaid (a protein drink) 4 oz. TID with snacks and 4 oz. of Ensure with meals.
6/19/15- Dietary note by the CDM- The resident continued to lose some weight, but the family was not concerned. The resident's family stated the resident was always a very thin person. The resident ate 25-50% of meals and snacks and had an order for 4 oz. of Arginaid for snacks and 4 oz. of Ensure at meals.

Review of a fax from the physician on 2/20/15 revealed an order to start a supplement of choice 4 oz. TID with meals for weight loss, however staff did not update the care plan with the new order until 2/24/15.

Review of a fax from the physician on 3/24/15 revealed an order to increase the resident's supplement to 8 oz. TID with meals for continued weight loss.

Observation on 6/17/15 at 12:27 PM, the resident sat in the dining room and received, pears, lasagna, green beans, french bread, peach cobbler, water, cranberry juice, milk, and chocolate boost. Staff cut up the resident's food for him/her. At 12:45 PM direct care staff G assisted the resident to eat. At 1 PM, the resident remained at the dining table and staff G encouraged the resident to eat and drink. The resident ate all of his/her lasagna, a few bites of beans, a few bites of cobber, and a few bites of bread. The resident drank 90% of his/her boost, and all of his/her milk.

Interview with licensed nurse C on 6/18/15 at 1:20 PM revealed resident #5 did not have a very big appetite, but could voice hunger and thirst. Staff I reported staff encouraged him/her to eat and

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he/she received a supplement TID. Staff I reported the resident could feed him/herself but liked to have staff feed him/her. Staff I reported he/she did not know of an exact amount, but it seemed like the resident had lost a little bit of weight. Staff C reported the weekend direct care staff obtained the weights for the residents, then the CDM and administrative nurse J reviewed the weights.

Interview with dietary staff D on 6/18/15 at 1:41 PM revealed they had discussed resident #5 during care plan meetings and his/her family thought he/she was doing great. Staff D reported he/she thought maybe they needed to change the timing of the resident's supplement, but reported the resident did not have a physician's order yet to change it.

Interview with administrative nurse J on 7/14/15 at 2:12 PM revealed dietary supplements were documented by the person recording dietary intake and the direct care staff that set up for meals and snacks were the main staff members that documented the dietary intake and supplement intake. Staff J also reported he/she expected the nurses to document supplement administration in the treatment section of the MAR. Staff J reported he/she worked with dietary staff D to follow up on any dietician recommendations and discussed the recommendations and weights weekly at care plan meetings. Staff J reported staff weighed each resident weekly. Staff J reported resident #5 had a weight loss following his/her admission from a geropsychiatric unit (12/12/14) and upon admission, staff began decreasing his/her psychotropic medications immediately because the resident was overmedicated. At that time

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he/she required feeding assistance for all meals and still required set up assistance and strong encouragement with meals. After reducing his/her medications, he/she became better able to feed him/herself and interacted with others and continued to slowly gain back the weight he/she lost while staff tapered his/her medications. At times, staff J reported, the resident could be very forceful in his/her refusal to eat.

Interview with dietary consultant staff N on 7/22/15 at 4:12 PM revealed the facility notified him/her if a resident's weights trended downward if it was over 3-5% in a month and that was what he/she expected. Consultant N also reported he/she charted on all the residents every 3 months. Consultant N reported resident #5 moved to the long-term care facility from skilled care at the hospital a while prior to the weight loss. He/she reported the resident just was not eating or doing a lot at that time and he/she did not recall any edema or diuresis (use of medications to rid the body of excess fluids) at that time. Consultant N reported discussing the resident's weight loss with his/her family member who did not seem concerned at all. Consultant N reported after he/she saw the resident, the CDM followed up on his/her recommendations and nursing could also read his/her note with recommendations to follow up as well. Per consultant N, staff normally followed up on his/her recommendations by the next day, which was his/her expectation. Consultant N did not know staff did not follow up on his/her recommendation to start supplements on 1/22/15 until 2/20/15.

A phone interview was attempted with the physician on 7/20/15 at 1:25 PM and a message left. The physician did not return the phone call.

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Review of the facility policy for Weights, revised 12/2008, revealed staff were to call the dietary manager if a resident had 5% weight loss or more within 30 days or 10% or more in 180 days and request a dietary consult. The dietary manager and the director of nursing would consult on weight losses and discuss interventions to prevent further weight loss problems.

Review of the facility policy for Nutritional Services, revised 08/2010, revealed high risk patients would be identified and reassessed weekly. The nursing staff or physician could order a reassessment of nutritional needs as necessary for significant weight loss, a significant change in eating habits or lab work indicative of nutritional concern. The following were high risk patients: unplanned weight loss of 5% over one month, 7.5% over 3 months, 10% over 6 months, serum albumin less than 3.5 mg/dL, or stage II or greater pressure ulcer.

The facility failed to implement interventions to prevent further weight loss after resident #5 started to steadily lose a significant amount of weight (9.3%) from 1/16/15- 2/20/15 and then again from 3/30/15-6/17/15, when the resident experienced more continued weight loss (4.2%).

- Review of resident #4's signed physician history and physical dated 2/25/15 revealed the following diagnoses: multiple sclerosis (progressive disease of the nerve fibers of the brain and spinal cord), previous flap closure (surgical procedure to close an open wound) of coccyx wound, and right ischial (part of the hip bone) wound, depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness

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and emptiness), and lower extremity edema (swelling)

Review of the quarterly MDS (minimum data set) dated 2/5/15 revealed a BIMS (brief interview for mental status) score of 9, indicating moderate cognitive impairment. Resident #4 required total assistance of 2 or more staff for bed mobility and transfers and supervision and set-up for eating. Staff provided the resident a therapeutic diet and resident #4 had not experienced any weight loss.

Review of an annual MDS dated 5/4/15 revealed resident #4 had a BIMS score of 11, indicating moderate cognitive impairment. The resident required extensive assistance of 2 or more staff for bed mobility. He/she required total assistance of 2 or more staff for transfers. The resident received nutritional/hydration interventions.

Review of the Nutritional Status CAA (Care Area Assessment) dated 5/7/15 revealed resident #4 received a NCS (no concentrated sweets) diet with a protein supplement TID (three times a day). Resident #4 preferred Special K (brand of supplement) and watched his/her weight limiting and often refusing desserts and breads. The resident asked for small portions and ate 50-100% of his/her meals. Resident #4 could make his/her own menu choices and feed him/herself after set-up from staff. He/she needed to have meals and drinks placed where he/she could easily reach items as he/she had a limited reach. The resident had a plate guard on his/her plate at meal times. He/she also preferred to sleep in the mornings and usually did not eat breakfast.

Review of the ADL (activities of daily living) CAA

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dated 5/7/15 revealed resident #4 had a diagnosis of MS (multiple sclerosis), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and dementia (progressive mental disorder characterized by failing memory, confusion). The resident was hospitalized in 2/2015 for flap repair to his/her buttocks wound that resolved well. The resident had a sitting limit of 90 minutes at a time TID and needed reminders of this limit due to the resident wanted to sit up longer. Resident #4 complied with the sitting limit after explanation provided. The resident depended on staff for ADL care, transferred via lift sling, needed staff to reposition him/her, made his/her needs known, made menu choices, and fed him/herself after set-up assist.

Review of resident #4 ' s care plan, last reviewed by staff on 5/6/15, revealed the resident had total dependence on staff for his/her ADLs and his/her teeth were in good repair. Interventions included:
10/30/12- Provide setup assistance at mealtime. Educate the resident on the importance of protein as he/she tended to cut back on meats to decrease calorie consumption as he/she wanted to lose weight.
Weigh the resident weekly.
Ensure the dietician assessed him/her every 3 months.
Administer vitamin supplements daily as ordered.
Monitor food intake at meals and snacks.
Assist with a supplement each day and encourage him/her to drink it.
Encourage him/her to eat at least 75% of the meal, if not, offer a substitute.
2/11/13- Remind him/her the importance of eating as he/she got so focused on weight loss that

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he/she forgot he/she needed nutrition and calories for wound healing.
6/19/13 -Please ensure the resident received increased protein with his/her meals for proper skin/wound prevention.
2/4/14- The resident requested small portions and if he/she was still hungry, he/she asked for more.
12/17/14- Provide a plate guard on the resident ' s plate so the food did not fall off.
2/12/15- Provide a special K drink with each meal.
3/24/15- Multivitamin and zinc added to promote wound healing

Review of the resident ' s lab reports revealed:
10/13/14- Albumin (blood test used to measure the amount of protein in the blood, used in part to determine a person ' s nutritional status) 4.3 grams per deciliter (g/dL) with the normal range of 3.5-4.8 g/dL.
2/25/15- Albumin 3.3 g/dL (low)
3/2/15- Albumin 2.7g/dL (low)
3/9/15- Albumin 3.1 g/dL (low)
3/16/15- Albumin 3.4g/dL (low)
3/23/15- Albumin 3.5 g/dL (normal)

Review of the resident ' s weights revealed:
12/30/14- 168.5 lbs. (pounds)
1/7/15- 170 lbs.
1/14/15- 170.5 lbs.
1/29/15- 168.4 lbs.
2/20/15- 163.5 lbs., a weight loss of 7 lbs., (4% of his/her body weight), since 1/14/15 (approximately one month prior).
The resident was hospitalized from 2/24/15-3/24/15 for surgery on a wound.
3/30/15- 152 lbs.
4/8/15- 152.5 lbs., a weight loss of 18 lbs. (10.6%

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of his/her body weight) since 1/14/15 (approximately 3 months prior).
4/27/15- 153.4 lbs.
5/13/15- 154 lbs.
6/3/15- 153.5 lbs.
6/11/15- 155 lbs.

Review of the resident's progress notes revealed:
12/16/14- The resident blurted out dietary restrictions for other residents in the dining room to staff while not following his/her own diet.
1/12/15- Received orders for zinc and a multivitamin to promote wound healing.
2/2/15- Staff sent a fax to the physician asking for special K protein drink to be given with meals due to condition of the resident's wound.
2/3/15- Received order for special K protein drink with meals.
2/7/15- Dietary note by the dietician- The resident experienced a 14.86% weight loss over the past 6 months. The resident received a NCS (no concentrated sweets) diet with variable intake, and generally refused breakfast and some other meals. The resident's weight loss had been beneficial, but further weight loss should be avoided. The resident weighed 168.4 lbs.
2/18/15 Dietary note by the CDM (certified dietary manager)- Limited concentrated sweets diet and to aide in him/her losing weight, he/she also refused breakfast because he/she wanted to sleep in. The resident received a supplement of choice for added protein. Ate 100% of lunch and 25-100% of supper.
3/31/15 Dietary note by the dietician-The resident weighed 152 lbs. and received a regular NCS diet. The resident previously received a protein supplement of choice with meals but the physician did not re-order it since his/her return from the hospital. The resident refused breakfast

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daily and ate 50-100% of lunch and dinner. The resident received vitamin C. The dietician recommended re-instating the protein supplement of choice with lunch and dinner to help reduce weight loss and aid in wound healing.
4/27/15 Dietary note by the CDM- The resident requested a snack of special K high protein drink BID (twice a day) and weighed 152.4 lbs.
4/29/15- Staff received an order for a supplement of the resident ' s choice TID (three times a day) with meals
5/6/15- Staff received an order to change the resident ' s diet to NCS diet as the resident wished to continue to lose weight.
5/8/15 Dietary note by the dietician- The resident weighed 153 lbs. and received protein supplements TID with meals per his/her request. The resident also received vitamin C, calcium carbonate, and zinc.

Review of a physician order sheet dated 10/1/14 revealed the following orders:
*Regular NCS 3 times per day at 8:00 a.m., 12:00 p.m., and 5:00 p.m.
*Supplement of choice daily at 8:00 a.m. for nutrition/wound preventions.

Review of the resident's oral intake from 10/1/14-6/18/15 revealed staff did not document nutritional supplements until 2/9/15, even though the care plan listed he/she should have a supplement daily since 10/30/12. From 2/9/15-6/17/15, the resident received a supplement 79 times out of 381 opportunities.

Review of the TAR (treatment administration record) for October 2014 revealed:
*Supplement not administered 9 times out of 31 days with follow-up that the resident remained in

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bed at breakfast and declined supplement all 9 times

Review of the TAR for November 2014 revealed:
*Supplement not administered 11 times out of 30 days with follow-up that the resident remained in bed at breakfast and declined supplement all 11 times

Review of the TAR for December 2014 revealed:
*Supplement not administered 7 times out of 31 days with follow-up that the resident remained in bed at breakfast and declined supplement 6 times; on 12/8/14 follow-up of protein supplement added to lunch Cappuccino.

Review of the TAR for January 2015 revealed:
*Supplement not administered 12 times out of 31 days with follow-up that the resident remained in bed at breakfast and declined supplement

Review of the TAR for February 2015 revealed:
*Supplement not administered 8 times out of 28 days with follow-up that the resident remained in bed at breakfast and declined supplement

Review of the TARs for April 2015 revealed:
*Treatment of supplement of choice TID with meals at 8:00 a.m., 12:00 p.m., and 5:00 p.m. resident preferred Special K. Staff did not administer the supplement twice on 4/30/15 due to refusal.

Review of the Tar for May 2015 revealed:
*Supplement not administered 12 times out of 31 days with follow-up that the resident remained in bed at breakfast and declined supplement, and he/she refused the supplement twice.

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Review of the TAR for June 1-29, 2015 revealed: *Supplement not administered 12 times out of 31 days with follow-up that the resident remained in bed at breakfast and declined supplement, and refused the supplement 5 times.

Review of a hospital physician progress note dated 3/20/15 revealed the physician encouraged the resident to take control of his/her health and skin care/wound prevention with a high protein diet and the resident was non-compliant.

Review of a hospital physician progress note dated 3/23/15 revealed the resident was noncompliant with cares.

Observation on 6/17/15 at 11:45 AM revealed the resident's room door closed with several voices coming from inside. At 11:59 AM, the door to the resident's room sat open and the resident was not inside the room. A Hoyer lift (mechanical lifting/transfer device) sat inside the room. At 12 PM, the resident sat in the dining room and reported the food was good. The resident received lasagna, green beans, chocolate shake, water, iced coffee, and lettuce salad. The resident fed him/herself and ate everything except 1/2 of the green beans.

Observation on 6/17/15 at 5:07 PM revealed the resident chose an alternate meal of popcorn shrimp, French fries, and apple salad. The resident had a chocolate shake and water to drink and fed him/herself everything.

Interview with direct care staff B on 6/18/15 at 11:08 AM revealed the resident required setup assistance for meals and fed him/herself.

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Interview with licensed nurse C on 6/18/15 at 1:20 PM revealed the resident fed him/herself. The resident received zinc, a multivitamin, and drank protein supplements twice a day unless he/she refused. Staff C reported nursing documented supplements intake in the MAR (medication administration record) /TAR. Staff C reported the resident ' s weight was stable at the time and the resident usually skipped breakfast, and then ate lunch and supper well. Staff C reported the resident lost some weight in the past so the physician added protein supplements. Staff C reported the weekend direct care staff obtained weights each weekend, then dietary staff and administrative nurse J reviewed the weights.

Interview with dietary staff D on 6/18/15 at 1:41 PM revealed the resident received Special K supplements per his/her request. Staff D reported the nursing staff documented whether or not the resident received or consumed the supplements. Staff D reported the resident preferred not to eat breakfast and slept in and wanted to lose weight. Staff D reported he/she thought the resident was young enough that he/she still wanted to be thin. Staff D reported the resident ' s would not eat everything and was kind of picky because he/she did not want to gain any weight. Staff D reported the staff tried to encourage protein intake, especially for the wound healing. Staff D reported he/she reviewed the weights of the resident ' s he/she care planned weekly and then in care plan meetings he/she discussed the resident ' s appetite and weights. Staff D reported the dietician looked at weights and made recommendations after weight changes and during care plan reviews. Staff D reported the dietician came to the facility monthly.

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Interview with administrative nurse J on 7/14/15 at 2:12 PM revealed dietary supplements were documented by the person recording dietary intake and the direct care staff that set up for meals and snacks were the main staff members that documented the dietary intake and supplement intake. Staff J also reported he/she expected the nurses to document supplement administration in the treatment section of the MAR. Staff J reported he/she worked with dietary staff D to follow up on any dietician recommendations and discussed the recommendations and weights weekly at care plan meetings. Staff J reported staff weighed each resident weekly. Staff J reported resident #4 had been on his/her own weight loss plan for at least 2 years. The resident wanted to lose weight and worked very hard to do it. Staff J reported resident #4 restricted what he/she ate and drank and refused to eat things he/she thought were too high in calories which could cause weight gain. Staff J reported the resident had good understanding about the things he/she should and should not eat to lose weight. Staff J reported the resident lost 20 lbs. in the past 180 days and was ecstatic about it. Staff J reported resident #4 agreed to drink a protein drink to add calories and protein to his/her diet a couple times per day.

A phone interview was attempted with the physician on 7/20/15 at 1:25 PM and a message left. The physician did not return the phone call.

Review of the facility policy for Weights, revised 12/2008, revealed staff were to call the dietary manager if a resident had 5% weight loss or more within 30 days or 10% or more in 180 days and request a dietary consult. The dietary manager

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F 325	Continued From page 85 and the director of nursing would consult on weight losses and discuss interventions to prevent further weight loss problems. Review of the facility policy for Nutritional Services, revised 08/2010, revealed high risk patients would be identified and reassessed weekly. The nursing staff or physician could order a reassessment of nutritional needs as necessary for significant weight loss, a significant change in eating habits or lab work indicative of nutritional concern. The following were high risk patients: unplanned weight loss of 5% over one month, 7.5% over 3 months, 10% over 6 months, serum albumin less than 3.5 mg/dL, or stage II or greater pressure ulcer. The facility failed to ensure resident #4 developed and implemented appropriate interventions to maintain the resident ' s nutritional status within acceptable parameters, resulting in a weight loss of 10.5% in 3 months. The facility also failed to collaborate with the resident ' s physician to develop a weight loss plan for resident #4, as he/she desired to lose weight.	F 325		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be	F 431		

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labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 36 residents. Based on observation, interview, and record review the facility failed to properly store medications in locked compartments in labeled containers.

Findings included:

- An observation 4/30/15 at 5:20 PM revealed a partially open desk drawer in the unlocked activity room that contained:
*a partially full bottle of Lipozene (a medication for weight loss)

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*a medication bottle of Metoprolol (a medication to treat high blood pressure) with one pill left in the bottle
*two punch cards with 6 pills of Celebrex (an anti-inflammatory medication)
*two pink scored medication tablets laying out of the package in the bottom of the drawer

Observation on 4/30/15 at 5:00 PM revealed 2 treatment carts next to each side of the nursing station. Each cart had a key in the lock and the carts were unlocked. The nursing station was unattended.

Interview with licensed nursing staff K on 4/30/15 at 5:05 PM revealed some nurses left the keys in the treatment carts, it just depended on the nurse. Staff K reported the carts contained medicated creams and powders. He/she opened a drawer of the cart to reveal Nystatin powders (an antifungal) and Icy Hot (medicated pain relief) creams.

Interview with administrative nurse J on 4/30/15 at 5:30 PM revealed he/she expected medications to be locked up.

Review of the facility policy for Medication Access, revised 07/2011, revealed the facility would use the PYXIS medication station as a storage system for the control and distribution of medications. The policy did not include medications were to be locked and only authorized persons were to have access.

The facility failed to ensure medications were stored securely, labeled properly, and only authorized staff had access to the medications.